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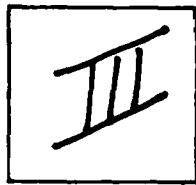
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Appendices - Volume II

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A HANDBOOK
FOR ALCOHOL AND DRUG CONTROL OFFICERS
APPENDICES - VOLUME II

SOCIAL PROCESSES TECHNICAL AREA

INDIVIDUAL TRAINING & PERFORMANCE RESEARCH LABORATORY

February 1975



U. S. Army

Research Institute for the Behavioral and Social Sciences

In cooperation with Arthur D. Little, Inc.

Approved for public release; distribution unlimited

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**U. S. ARMY RESEARCH INSTITUTE
FOR THE BEHAVIORAL AND SOCIAL SCIENCES
A Field Operating Agency under the Jurisdiction of the
Deputy Chief of Staff for Personnel**

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**Research accomplished
under contract to the Department of the Army**

Arthur D. Little, Inc.

A HANDBOOK

FOR ALCOHOL AND DRUG CONTROL OFFICERS

APPENDICES - VOLUME II

SOCIAL PROCESSES TECHNICAL AREA

INDIVIDUAL TRAINING & PERFORMANCE RESEARCH LABORATORY

February 1975

U. S. ARMY RESEARCH INSTITUTE FOR THE BEHAVIORAL AND SOCIAL SCIENCES

Office, Deputy Chief of Staff for Personnel
Department of the Army
1300 Wilson Boulevard, Arlington, Virginia 22209

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Institutional Change

In cooperation with Arthur D. Little, Inc.

**MANAGING ALCOHOL AND DRUG ABUSE PREVENTION AND CONTROL PROGRAMS:
A HANDBOOK FOR
ALCOHOL AND DRUG CONTROL OFFICERS
APPENDICES**

A Report to the

**United States Army Research Institute
for the Behavioral and Social Sciences**

February 1975

C-76600

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APPENDIX A

MEASURING THE PROBLEM:
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APPENDIX A

MEASURING THE PROBLEM: TALKING WITH DRUG USERS AND PROBLEM DRINKERS

Information on substance abuse is hard to come by since drug use is illegal and both drug use and problem drinking are socially unacceptable (although they may be status symbols within particular groups). People are often reluctant to discuss their use of drugs or alcohol, and they may distort the facts--by minimizing their use, by rationalizing their use, by saying "everybody does it," and so on.

Even so, one of the best ways to obtain an understanding of why and how people use drugs or drink to excess is to talk with drug users and problem drinkers. How reliable and useful the answers are may depend on the interviewer, the number of people interviewed, the setting and conditions of the interview, and the approach used.¹

1. WHO SHOULD TALK WITH SUBSTANCE ABUSERS¹

The person talking with substance abusers should be someone who is not in a position to penalize individuals for their actions, attitudes, or beliefs regarding alcohol and drugs. Someone in direct authority or with law enforcement responsibilities is likely to get inaccurate information--the soldier will feel compelled to give some answer to questions, but may tailor the answers to avoid possible punishment.

1. L. Annette Abrams, Emily F. Garfield, and John D. Swisher, Eds., Accountability in Drug Education (Washington, DC: The Drug Abuse Council, November 1973), deals with some of these issues on pp. 47-52.

The person talking with substance abusers must be able to use the exchange as a means of information gathering rather than a means of changing attitudes and behavior. He must avoid showing approval or disapproval of statements made by the respondent. The tone should be friendly but neutral. Some training in interpersonal behavior or group dynamics is very helpful preparation for such a role.

2. WHOM TO INTERVIEW

Interviews should be held with known drug users and problem drinkers. Usually these will be people who have been confirmed as substance abusers, but others should also be interviewed if their identity is known, in case there are differences in attitude, etc., related to whether the individual is confirmed.

The purpose of the interviews is to obtain a general sense of the factors influencing drug use and problem drinking, and the needs a prevention and control program should be designed to meet. Interviews with about ten drug users and ten problem drinkers should be sufficient for this purpose.

3. THE SETTING

The setting helps to set the tone of the conversation. Rather than sitting across a desk from one another, the interviewer and the individual or group being interviewed should sit in comfortable chairs facing each other without intervening furniture barriers or other unnecessary indications of rank/status. A "neutral" spot, such as a meeting room, is

preferable to the territory of either party (e.g., the ADCO's office or the soldier's recreation room). Privacy is also essential.

4. CONDITIONS

Respondents must be assured that their identity will not be revealed (for instance, in write-ups of the conversation) and that nothing will happen to them as a result of the conversation. It is not enough to give assurances; careful attention must be given to making sure that there is no possibility of punishment due to the interview--or of identification, in the case of soldiers who have not been confirmed as substance abusers. There should be no list of soldiers interviewed in any files, and commanding officers and unit commanders should not be aware of the conversation or its intent.

5. APPROACH

The interviewer's manner should be designed to put the respondent at ease and set the tone as a relaxed, informal conversation. The interview should begin with broad, open-ended questions and focus in on the details later. This approach allows the respondent to identify the most important areas for further discussion.

The conversation can be an individual interview or a group discussion depending on the kind of information desired. Individual conversations allow for a deeper probing of each respondent's history and motivations, but may also make the individual feel more "on the spot." A group situation is usually more relaxing and has the additional

advantage that participants may challenge or support one another's statements, generating further discussion around the topics that are most on people's minds. Thus, the individual conversation will provide more insight into one person, while the group often permits better focusing on the important issues and forces closer inspection of those issues.

Of the two approaches, group discussions require more skills on the part of the moderator: he/she must control "bandwagoning" due to a dominant personality, must encourage the more silent to voice their views (which can be different from the views of the more verbal people), and must keep the discussion focused without forcing its direction.

Forms A-1 through A-4, at the end of this appendix, are sample interview guides for use in individual and group sessions with drug users and problem drinkers.

6. WHAT TO DO WITH THE DATA

The main purpose of the discussions/interviews, as mentioned above, is to gain insights into the nature of drug use and problem drinking, and to uncover major needs toward which the ADAPCP should be addressed. For this purpose, it may not be necessary to do anything further.

If, however, summaries of these conversations are desired, the interviewer should take notes (or, in the case of groups, record the discussions, as long as respondents are aware they are being recorded). The process of summarizing requires reading (or listening to) the responses for each train of thought, or question, and sorting out differences in and patterns of response. Types of response should be

noted, the strength of response should be considered, and the motivations underlying responses should be sought.

To be most useful, the summary probably should not be presented question-by-question according to the interview format. Instead, it should pull together the interview results around issues of major importance in planning the program. Form A-5, which follows the sample interview forms at the end of this appendix, shows a sample outline for summarizing results.

FORM A-1
SAMPLE INDIVIDUAL INTERVIEW WITH A DRUG USER

I'd like to talk with you today about drug use and problem drinking here on this post. Your comments will be held in strictest confidence and will be anonymous--not associated with your name in any way.

1. What is the extent of drug use here on this post?

Probes: How many soldiers on the post are occasionally or frequently using some kind of drug without a prescription? How many in your unit? What kinds of drugs are used? Which drugs are used by more people? Which are used most intensively by those using them? Are drugs more likely to be used on duty, off duty but on the post, or off post? Which ones are more likely to be used in which circumstances?

2. What about heavy drinking?

Probes: How many on the post drink more than is good for them? In your unit? When are they most likely to do this--on duty, off duty but on the post, off duty and off post?

3. We've talked about drug use on and off the post. In general, how easy is it to get drugs around here?

Probes: On the post? Off the post? What is easiest to get? What most difficult? (Avoid even appearing to ask for specifics that might make people liable to criminal action.)

FORM A-1 (Continued)

4. You've told me that there is (some, quite a bit, a lot) of drug use and (some, quite a bit, a lot) of heavy drinking on this post. What is the reaction to this in your unit?

Probes: What happens when someone is suspected of using drugs or of heavy drinking? (Note differences between on duty, off duty/on post, off duty/off post; note differences from one drug to another, or from alcohol to drugs.) What if they are caught using drugs or under the influence of alcohol? (Probe for action both at the unit level and at higher levels. Also probe for the variables which affect the action taken--type of drug, whether or not it is the first time, etc.)

5. Why do you think people use drugs in the Army?

Probe to determine importance of peer group pressure, boredom, kicks, etc.

6. What about yourself--where do you stand on drug use and heavy drinking?

Probes: What do you personally feel about people using drugs and drinking too heavily? (Attitudes toward drug use; distinctions made between drugs and alcohol, among drugs, by when used.)

FORM A-1 (Continued)

NOTE: IF RESPONDENT IS CONFIRMED OR MENTIONS OWN DRUG USE/HEAVY DRINKING WHEN ANSWERING QUESTION 6, SKIP TO QUESTION 7 PROBES. OTHERWISE, ASK QUESTION 7.

7. Have you ever used any kind of drug without a prescription or drunk too heavily?

Probes: Which drugs have you personally used? Did your use change on this post? Did you try any new drugs on this post? What led to these changes or new drugs? Has your alcohol consumption changed on this post? What led to the change?

NOTE: IF THE RESPONDENT IS NOT CONFIRMED AND DOES NOT ADMIT TO HAVING USED OR USING DRUGS, TERMINATE. IF THE RESPONDENT DOES NOT ADMIT TO DRINKING TOO HEAVILY, ELIMINATE ANY OTHER ALCOHOL-RELATED QUESTIONS.

8. How did you happen to try (name drug tried on this post or first drug used)? How did you happen to get into heavy drinking?

Probes: Do not accept an answer "it was there," etc.

Probe: "Had you had the opportunity to use drugs before? What made you try it this time?" (Probe for frame of mind.)

FORM A-1 (Continued)

9. What about drug use on this post--why do you (did you) use drugs here? How about heavy drinking?

Probes: Note differences between response under Question 5 and here and probe for peer group pressures, boredom, habit, kicks, etc.

10. How does one go about obtaining drugs here?

Probes: How long does it take for newcomers to learn the drug sources--are they approached or do they have to start asking around? How open/closed is the drug supply?

NOTE: IF RESPONDENT IS CONFIRMED, SKIP TO QUESTION 12.

11. To your knowledge, have you been identified as a drug user? Problem drinker?

Probes: How were you (do you suspect you were) identified?

NOTE: IF RESPONDENT DOES NOT ADMIT TO BEING CONFIRMED FOR DRUG USE OR FOR PROBLEM DRINKING, SKIP TO QUESTION 13.

FORM A-1 (Continued)

12. What has happened to you as a result of being identified?

Probes: Did attitudes toward you change in any way? Did behavior change? How were these changes manifested? (Probe for perceptions of punishment through unpleasant tasks, "shakedowns," etc.). Were you told about the exemption policy? Were you told about the treatment program? (Probe to see if persuaded/coerced to enter programs.) Did you ever receive a disciplinary action due to drug use? Heavy drinking?

13. Where are you at now?

Probes: Have you stopped using any drugs? Which ones and why? Have you stopped drinking more than is good for you? How do you feel about yourself, where you are going, the Army, and so on? What, if anything, do you feel we could be doing to help you?

THANK RESPONDENT AND TERMINATE

FORM A-2

SAMPLE INDIVIDUAL INTERVIEW WITH A PROBLEM DRINKER

I'd like to talk with you today about problem drinking and drug use here on this post. Your comments will be held in strictest confidence and will be anonymous--not associated with your name in any way.

1. What is the extent of heavy drinking on this post?

Probes: How many on the post drink more than is good for them? In your unit? When are they most likely to do this--on duty, off duty but on the post, off duty and off post?

2. What about drug use?

Probes: How many soldiers on the post are occasionally or frequently using some kind of drug without a prescription? How many in your unit? What kinds of drugs are used? Which drugs are used by more people? Which are used more intensively by those using them? Are drugs more likely to be used on duty, off duty but on the post, or off post? Which ones are more likely to be used in which circumstances?

3. You've told me that there is (some, quite a bit, a lot) of heavy drinking and (some, quite a bit, a lot) of drug use on this post. What is the reaction to this in your unit?

Probes: What happens when someone is suspected of heavy drinking or of using drugs? (Note differences between on duty, off duty/on post, off duty/off post; note differences from one

FORM A-2 (Continued)

drug to another, or from alcohol to drugs.) What if they are caught using drugs or under the influence of alcohol? (Probe for action at the unit level, and at higher levels. Also probe for the variables which affect the action taken--whether or not it is the first time, type of drug, etc.)

4. Why do you think people drink more than is good for them?

Probe to determine importance of peer group pressure, boredom, kicks, etc.

5. What about yourself--where do you stand on drug use and heavy drinking?

Probes: What do you personally feel about people using drugs and drinking too heavily? (Attitudes toward drug use; distinctions made between drugs and alcohol, among drugs, by when used.)

NOTE: IF RESPONDENT IS CONFIRMED OR MENTIONS OWN HEAVY DRINKING/DRUG USE WHEN ANSWERING QUESTIONS, SKIP TO QUESTION 6 PROBES. OTHERWISE, ASK QUESTION 6.

FORM A-2 (Continued)

6. Have you ever used any kind of drug without a prescription or drunk too heavily?

Probes: Which drugs have you personally used? Did your use change on this post? Did you try any new drugs on this post? What led to these changes or new drugs? Has your alcohol consumption changed on this post? What led to the change?

NOTE: IF THE RESPONDENT IS NOT CONFIRMED AND DOES NOT ADMIT TO DRINKING TOO MUCH, TERMINATE. IF THE RESPONDENT DOES NOT ADMIT TO USING DRUGS ON THIS POST, ELIMINATE ANY OTHER DRUG-RELATED QUESTIONS.

7. How did you happen to get into heavy drinking on this post?
How did you happen to start using (name drugs used on this post)?

Probes: Do not accept a "just did" type of answer, but note, "Alcohol has (drugs have) always been around; what changed that you began to drink more heavily (use that drug)?"
(Probe for frame of mind and note differences between response here and under Question 4.)

NOTE: IF RESPONDENT IS CONFIRMED, SKIP TO QUESTION 9.

FORM A-2 (Continued)

8. To your knowledge, have you ever been identified as a problem drinker--one that drinks more than is good for him (her)? Drug user?

Probes: How were you (do you suspect you were) identified?

NOTE: IF RESPONDENT DOES NOT ADMIT TO BEING CONFIRMED FOR DRUG USE OR FOR PROBLEM DRINKING, SKIP TO QUESTION 10.

9. What has happened to you as a result of being identified?

Probes: Did attitudes toward you change in any way? Did behavior change? How were these changes manifested? (Probe for perceptions of punishment through unpleasant tasks, "shakedowns," etc.) Were you told about the exemption policy? Were you told about the treatment program? (Probe to see if persuaded/coerced to enter programs.) Did you ever receive a disciplinary action due to drug use? Heavy drinking?

10. Where are you at now?

Probe: Have you stopped using any drugs? Which ones and why? Have you stopped drinking more than is good for you? How do you feel about yourself, where you are going, the Army, and so on? What, if anything, do you feel we could be doing to help you?

THANK RESPONDENT AND TERMINATE.

FORM A-3
SAMPLE GROUP DISCUSSION WITH DRUG USERS

I'd like to talk with you today about drug use and problem drinking here on this post. Your comments will be held in strictest confidence and will be anonymous--not associated with your names in any way.

1. What is the extent of drug use here on this post?

Probes: How many soldiers on the post are occasionally or frequently using some kind of drug without a prescription? How many in your unit? What kinds of drugs are used? Which drugs are used by more people? Which are used more intensively by those using them? Are drugs more likely to be used on duty, off duty but on the post, or off post? Which ones are more likely to be used in which circumstances?

2. What about heavy drinking?

Probes: How many on the post drink more than is good for them? In your unit? When are they most likely to do this--on duty, off duty but on the post, off duty and off post?

3. We've talked about drug use on and off the post. In general, how easy is it to get drugs around here?

Probes: On the post? Off the post? What is easiest to get? What most difficult? (Avoid even appearing to ask for specifics that might make people liable to criminal action.)

FORM A-3 (Continued)

4. You've told me that there is (some, quite a bit, a lot) of drug use and (some, quite a bit, a lot) of heavy drinking on this post. What is the reaction to this in your unit?

Probes: What happens when someone is suspected of using drugs or of heavy drinking? (Note differences between on duty, off duty/on post, off duty/off post; note differences from one drug to another, or from alcohol to drugs.) What if they are caught using drugs or under the influence of alcohol? (Probe for action both at the unit level and at higher levels. Also probe for the variables which affect the action taken--type of drug, whether or not it is the first time, etc.)

5. Why do you think people use drugs in the service?

Probe to determine importance of peer group pressure, boredom, kicks, etc.

6. What about yourselves--where do you stand on drug use and heavy drinking?

Probes: What do you personally feel about people using drugs and drinking too heavily? (Attitudes toward drug use; distinctions made between drugs and alcohol, among drugs, by when used. If own drug use/heavy drinking is mentioned, probe for frame of mind.)

FORM A-3 (Continued)

7. Why do you think people try drugs in the first place? (Note similarities/differences from Question 5 and challenge, where appropriate.)

NOTE: IF EVERYONE IN GROUP IS CONFIRMED, GO DIRECTLY TO QUESTION 8 PROBES.

8. Have any of you ever used any kind of drug without a prescription or drunk too heavily?

Probes: Which drugs have you personally used? Did your use change on this post? Did you try any new drugs on this post? What led to these changes or new drugs? Has your alcohol consumption changed on this post? What led to the change?

9. What about drug use on this post--why do you (did you) use drugs here? How about heavy drinking?

Probes: Again note differences between response under Question 5 and here, and probe for peer group pressures, boredom, kicks, etc.

10. How does one go about obtaining drugs here?

Probes: How long does it take for newcomers to learn the drug sources--are they approached or do they have to start asking around? How open/closed is the drug supply?

FORM A-3 (Continued)

11. What happens to people when they are identified?

Probes: Do attitudes/behavior toward them change in any way? Specifically, in what ways? (Probe perceptions of punishment through unpleasant tasks, "shakedowns," etc.) Are they told about the exemption policy? Treatment? Is there persuasion/coercion to enter programs? Do they receive disciplinary actions due to drug use/heavy drinking?

12. Where are you at now?

Probe: Have you stopped using any drugs? Which ones and why? Have you stopped drinking more than is good for you? How do you feel about yourself, where you are going, the Army, and so on? What, if anything, do you feel we could be doing to help you?

THANK GROUP AND TERMINATE

FORM A-4

SAMPLE GROUP DISCUSSION WITH PROBLEM DRINKERS

I'd like to talk with you today about problem drinking and drug use here on this post. Your comments will be held in strictest confidence and will be anonymous--not associated with your name in any way.

1. What is the extent of heavy drinking on this post?

Probes: How many on the post drink more than is good for them?

In your unit? When are they most likely to do this--on duty, off duty but on the post, off duty and off post?

2. What about drug use?

Probes: How many soldiers on the post are occasionally or frequently using some kind of drug without a prescription? How many in your unit? What kinds of drugs are used? Which drugs are used by more people? Which are used most intensively by those using them? Are drugs more likely to be used on duty, off duty but on the post, or off post? Which ones are more likely to be used in which circumstances?

FORM A-4 (Continued)

3. You've told me that there is (some, quite a bit, a lot) of heavy drinking and (some, quite a bit, a lot) of drug use on this post. What is the reaction to this in your unit?

Probes: What happens when someone is suspected of heavy drinking or of using drugs? (Note differences between on duty, off duty/on post, off duty/off post; note differences from one drug to another, or from alcohol to drugs.) What if they are caught using drugs or under the influence of alcohol? (Probe for action both at the unit level and at higher levels. Also probe for the variables which affect the action taken-- whether or not it is the first time, type of drug, etc.)

4. Why do you think people in the service drink more than is good for them?

Probe to determine importance of peer group pressure, boredom, kicks, etc.

5. What about yourself--where do you stand on drug use and heavy drinking?

Probes: What do you personally feel about people using drugs and drinking too heavily? (Attitudes toward drug use; distinctions made between drugs and alcohol, among drugs, by when used. If own heavy drinking/drug use is mentioned, probe for frame of mind.)

NOTE: IF GROUP IS OF CONFIRMED PROBLEM DRINKERS, GO DIRECTLY TO QUESTION 6 PROBES.

FORM A-4 (Continued)

6. Have any of you ever used any kind of drug without a prescription or drunk to heavily?

Probes: Which drugs have you personally used? Did your use change on this post? Did you try any new drugs on this post? What led to these changes or new drugs? Has your alcohol consumption changed on this post? What led to the change?

7. How did you happen to get into heavy drinking on this post? How did you happen to use (name any drugs used for the first time on this post)?

Probes: Do not accept a "just did" type of answer, but note "Alcohol has (drugs have) always been around. What changed that you began to drink more heavily (use that drug)?" (Probe for frame of mind and note differences between response here and under Question 4.)

8. What happens to people when they are identified?

Probes: Do attitudes/ behavior toward them change in any way? Specifically, in what ways? (Probe perceptions of punishment through unpleasant tasks, "shakedowns," etc.) Are they told about the exemption policy? Treatment? Is there persuasion/coercion to enter programs? Do they receive disciplinary actions due to drug use/heavy drinking?

FORM A-4 (Continued)

9. Where are you at now?

Probes: Have you stopped drinking more than is good for you? Have you stopped using any drugs? Which ones and why? How do you feel about yourself, where you are going, the Army, and so on? What, if anything, do you feel we could be doing to help you?

THANK GROUP AND TERMINATE

FORM A-5

SAMPLE OUTLINE FOR SUMMARIZING
INTERVIEWS WITH SUBSTANCE ABUSERS

A. How Extensive is Drug Use?

1. Location:

- On duty
- Off duty/on post
- Off duty/off post

2. Drug type

B. How Extensive is Problem Drinking?

1. On duty
2. Off duty/on post
3. Off duty/off post

C. What are Prevalent Attitudes Toward Drug Use/Problem Drinking?

1. By peers
2. By officers, as perceived by enlisted men

D. What Appear to be Motivating Factors in Substance Abuse?

1. Availability
2. Peer groups
3. Post circumstances
4. Other
5. Differences between motivating factors for initial experimentation and continued use

FORM A-5 (Continued)

E. What Factors Appear to Constrain/Inhibit Substance Abuse?

1. Availability
2. Peer groups
3. Officer reaction
4. Other
5. Differences between deterrents to initial and continued use

F. What Needs or Suggestions do Substance Abusers Report?

APPENDIX B

MEASURING THE PROBLEM: TALKING WITH LAW ENFORCEMENT PERSONNEL

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APPENDIX B

MEASURING THE PROBLEM: TALKING WITH LAW ENFORCEMENT PERSONNEL

1. WHY TALK WITH LAW ENFORCEMENT PERSONNEL?

There are usually two law enforcement agencies on a post that are directly concerned with drug use and to some extent problem drinking: the Military Police from the Provost Marshal's office and the Criminal Investigation Division. These can be valuable sources of information to the ADCO. Law enforcement efforts in dealing with drugs and their abuse existed long before there was a drug treatment program in the Army. These agencies may have charts and statistical information going back several years and indicating trends within the drug culture. Law enforcement's formal and informal policies and procedures can have an important impact on an ADCO's decision-making process. The ultimate goal of law enforcement efforts--to reduce and prevent substance abuse among the post's population--is consistent with the goals of the ADAPCP. Possibly most important, law enforcement personnel probably have a good understanding of the drug and alcohol situation, including availability of drugs and units where use is most prevalent. They receive inputs from the post's medical facility, as well as keeping their own records of arrests, etc.

2. INTERVIEW PARTICIPANTS AND OBJECTIVES

Ideally, the person talking with law enforcement personnel should be the ADCO himself or his immediate officer subordinate, both because this underscores the importance of the interview and because much of the

information to be discussed is confidential in its raw state (when it identifies individuals), though not in its aggregate state (summarizing trends), and its distribution should be strictly limited. It may be useful to interview either CID or MP staff, or both. To stimulate discussion, a possible approach is to interview all members of law enforcement in a group.

It is possible to obtain several types of information from law enforcement agencies. First, they have records of hard data from which summaries may be obtainable: arrest statistics, types of drug currently available, specific units on a post that are more prone to substance abuse than others, times when substance abuse is more prevalent (e.g., right after pay day or after return from a bivouac operation). In most circumstances, the information exchange will be one-sided. Law enforcement intelligence units often know in advance who the drug treatment program's next client will be, but it is essential that the ADCO avoid divulging information that could get someone in trouble with the law.

Then there are the less quantifiable data: what are the informal policies of the particular agency, what are their feelings, how do they perceive the drug situation presently? The interviewer should be alert for any changing attitudes and practices of the law enforcement effort that may affect future policies on treatment and rehabilitation.

At the conclusion of the interview(s), the interviewer might try to establish a plan for weekly or biweekly future meetings, so that an exchange of information can be continued on an ongoing basis. Similarly, he might try to arrange to receive copies of summaries of arrests made, which can provide data on statistical trends.

3. QUESTIONS TO ASK LAW ENFORCEMENT PERSONNEL

Before seeking hard statistics and law enforcement data, the interviewer should establish rapport with respondents and obtain their general views of the alcohol and drug problem and the relationship between law enforcement and the ADAPCP. The questioning might go as follows:

- What are cooperative ways in which the ADAPCP and law enforcement personnel can work together?
- What are the effects of drug use and problem drinking on operational readiness on the post?
- What do you see as the major issues in dealing with the drug problem? The alcohol problem?
- Are there any informal guidelines that law enforcement personnel currently use in handling the possession of marijuana by military personnel?
- What type of working relationship/information exchange do you have with the local community law enforcement officials?
- What kinds of general information sharing are possible between law enforcement officials and the ADCO's office?
- What kinds of drugs are currently a problem and are easily obtained on and off the post?
- How many soldiers from this installation were arrested by local civilian law enforcement authorities for drug use or alcohol-related offenses during the past fiscal year?

4. A WORD OF CAUTION

The drug program's credibility could be severely threatened if clients were aware that the ADCO's office had a working relationship with law enforcement. Meetings, telephone calls, and/or written memorandums should be handled with a great deal of caution, in recognition of the fact that if a potential or actual client were to see a representative of the ADAPCP talking with a law enforcement official, his confidence with the program staff could be severely threatened. However, this risk should not prevent program staff from seeking law enforcement assistance; the information is too valuable to be lost.

APPENDIX C

MEASURING THE PROBLEM:
TALKING WITH MEMBERS OF THE LEADERSHIP STRUCTURE

APPENDIX C

MEASURING THE PROBLEM; TALKING WITH MEMBERS OF THE LEADERSHIP STRUCTURE

The company commander and the first sergeant have considerable contact with the individual soldier. Depending on the unit, other members of the leadership structure (LS)--officers or NCOs--may spend an equal or greater amount of time with the men and may be knowledgeable regarding their personal problems and the alcohol and drug situation in the unit. ADDIC members will be an especially important source both of information and of policy guidance on problem drinkers and drug use.

On the other hand, no company commander or first sergeant wants his company to look bad. The interviewer should be alert to the possibility that their responses may be toned to make the problems appear less serious than they actually are. It is also very possible that the LS will view the ADAPCP as detrimental to mission accomplishment. Company commanders and first sergeants may often have little sympathy for confirmed drug users or problem drinkers who are removed from the company for rehabilitation. The interviewer may need to spend some time explaining the goals of the ADAPCP to them and asking how the ADCO or his staff might be able to help them with the drug or alcohol problem at the company level.

It is desirable to obtain a good cross-sampling of the LS, including company commanders, first sergeants, and others in the line chain of command, and including ADDIC members. The purpose of the interviews is both to obtain information and insights about needs and to develop

ongoing rapport with the LS. Some questions that the interviewer may wish to ask of LS members are as follows:

- How many of the people in your unit are presently using drugs or drinking excessively?
- What kinds of drugs are currently being abused?
- For what reasons do men in your unit drink too much or use drugs?
- What do you think the ADAPCP presently is doing?
- What do you think the ADAPCP should be doing?
- How much of your time is spent in dealing with alcohol or drug-related matters?
- Do you feel you need some special training or information to deal with the alcohol and drug problem and with users/abusers?
- Do you take a different view of hard drugs than of marijuana and hash?
- If a person from your unit is identified as a problem drinker or drug user, what do you do?
- What effect have substance abuse and the alcohol and drug treatment and rehabilitation (T/R) program had on your ability to carry out your mission?
- Would you prefer to deal with the substance abuser in your unit at the unit level, or do you feel it is more effective to place him in a T/R program, such as that of the ADAPCP? Why?

- How do you feel about the alcohol and drug education that you have received, and the time devoted to alcohol and drug education for your men?
- How can the ADCO help you deal with alcohol and drug problems in your unit?

Before leaving the members of the LS, the interviewer might express a desire to meet with them on a continuing basis in an effort to exchange information that may be mutually helpful.

APPENDIX D

MEASURING THE PROBLEM: ANONYMOUS SAMPLE SURVEYS

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APPENDIX D

MEASURING THE PROBLEM: ANONYMOUS SAMPLE SURVEYS

The survey, properly sampled and administered, is currently the most scientific way of measuring both the scope of the problem (for instance, how many drug users and problem drinkers there are on the post) and its nature (for example, what kinds of people are substance abusers and what motivates them). Because of the population size and the complexity of the information involved, access to a computer and data processing personnel will be necessary for tabulating the results.

1. WHO SHOULD BE SURVEYED?

Basically, there are three population groups to tap: those drug users/problem drinkers--past and present--who are known, i.e., confirmed; those who are not known to be drug users/problem drinkers but who might be (potential substance abusers); and the leadership structure. Two sets of survey questions are sufficient for the three groups: one for known and potential drug users/problem drinkers and the other for the leadership structure.

To obtain reliable information it is not necessary to survey everyone in the three groups. The following paragraphs describe how to sample each group for the surveys.

2. SAMPLING EACH POPULATION GROUP

Sampling may be defined as the selection of part of a whole (in this case, part of a population group) in such a way that by studying the part one can reach conclusions about the whole. It provides an alternative to

testing or measuring the entire population (all abusers, all potential abusers, and the entire leadership structure at the post). It is less costly and time-consuming than surveying everyone would be, and the results obtained usually will provide the level of accuracy necessary for reliable inferences about the entire population.

Accuracy is, of course, crucial. It is therefore important to make sure that the sample taken is representative of the total population group. The most reliable way to accomplish this is through random sampling. Described below are three possible approaches to random sampling.¹

Simple random sampling is a method of sample selection that gives each possible element in the group an equal probability of being chosen for the sample. Suppose, for example, that the post contains 10,000 soldiers who have not been confirmed as substance abusers, and ADAPCP staff want to study a 10% sample to develop inferences about drug use and problem drinking in the whole population group. It is essential that the sample be selected in such a way that it reflects the applicable characteristics of the total population. If, for instance, there are 2000 actual drug users in the total population, the 10% sample should contain approximately 200 drug users. To achieve this each of the 10,000 must have an equal chance of being selected. An example of a selection process that is not random is the choosing of the first 1000 soldiers arriving at the mess hall for evening meal. They do not comprise a random sample, because they have selected themselves; they may be the hungriest, or those who have appointments after dinner.

1. For a basic discussion of the theory of random sampling see William G. Cochran, Sampling Techniques (New York: John Wiley & Sons, 1959) and William Edward Deming, Some Theory of Sampling (New York: Dover Publications, 1966).

Either of these conditions might be related in some unknown way to drug or alcohol use, and consequently would not be representative of all soldiers on the post. Another example of non-random selection would be the selection of four entire companies of 250 soldiers. A truly random method for selecting a 10% sample in each of the three populations of interest (known abusers, potential abusers, leadership structure) is to select every person within each group whose social security number ends in a particular digit--for instance, two (2)--because the number has no specific relationship to any other characteristic.

Systematic random sampling, an alternative to simple random sampling, is a mechanism whereby the group is arranged in some ordered file (cards or lists of names for each of the three groups) and every Kth element is selected for the sample, with the starting point among the first K elements determined at random. In the example used above, the population is 10,000 and the desired sample 1000. Here, K = 10, or, in other words, every tenth card in the file will be selected. What is needed, besides the ordered file is a random starting point. A number between 1 and 10 can be selected at random (standard table of random digits, ten numbered slips of paper in a hat, etc.). If for instance the number selected is 3, the third soldier on the list is the first soldier chosen for the sample; the 13th soldier is the next selected, the 23rd is next, etc. The primary advantage of this technique over simple random sampling, is that, as long as there are cards or lists for each population, the sample can be selected without obtaining information about everyone in the group. In simple random sampling by social security number, every soldier's number has to be examined in order to reveal

those ending in the selected digit. In systematic random sampling, one simply takes every tenth (or Kth) name.

Stratified random sampling is aimed at avoiding a certain amount of sampling error inherent in simple random sampling (or systematic random sampling). Most simply stated it is a method whereby the total population is divided into a number of mutually exclusive sub-populations, each of which is sampled independently, using either the simple or systematic method. Some examples:

- sex (male, female)
- military pay grade (E-1, E-2, E-3, ... E-9)
- status (R.A., reservist)
- kind of unit
- age grouping
- race
- level of education
- age by sex by military pay grade

For purposes of sampling at a post, the recommended approach is to take a systematic random sample if the post already has easily retrievable ordered files of substance abusers, potential abusers (the entire post population for alcohol; all enlisted men for drugs) and the leadership structure. Otherwise, a simple random sample can be taken, utilizing some arbitrarily assigned number such as social security number.

There is no "right" sample size. The optimum size of the sample depends on available resources, the inherent variability of the data, the comparisons and tests to be made, and other factors. As a rule of

thumb, the sample size should generally be between 2% and 10% of the total population of interest, but not smaller than 400 nor usually greater than 2000. If tabulation of the test results reveals that the chosen sample has not accurately represented sub-populations on the post, then additional personnel can be surveyed, chosen by means of stratified random sampling.

3. HOW TO CONDUCT THE SURVEY

Normally there are three ways to survey populations: by face-to-face interview, by telephone interview, or by self-administered questionnaire. On an Army post, given the importance of anonymity, the best method is probably the self-administered questionnaire.

a. The Setting

Some of the survey questions are sensitive and soldiers may be uncomfortable answering them. In order to obtain complete responses, it is suggested that people fill out the questionnaire in large groups, overseen by someone from the ADCO's office who will state that all questions must be answered and that each questionnaire will be checked for completeness. Known and potential substance abusers should be mixed in these groups so that there is no clear evidence that everyone in a group has been chosen for a given purpose.

Mixing the samples does pose the problem of how to separate the responses into the two groups. The solution is to ask respondents on the questionnaire whether or not they use drugs or drink more than is

good for them, and if so whether or not they have been identified.

The leadership group should be a separate group, again overseen by an ADAPCP staff member who requests complete information.

Rooms for the group self-administered questionnaires should be large enough so that no respondent can see the responses of anyone else. Each respondent needs a surface for placing the questionnaire and checking responses, a seat, and adequate lighting. The room should be comfortably heated or ventilated, depending on the season. It should be reasonably insulated from noise distractions outside.

b. Conditions

Anonymity must be preserved for all respondents. There should be no question asked which would identify respondents; at the end of each session the lists of respondents should be destroyed.

c. Approach¹

At the end of this appendix are two sample survey questionnaires, one (Form D-1) for actual and potential substance abusers and the other (Form D-2) for the leadership structure. ADAPCP staff may find them appropriate to their own post or may wish to modify them or to design other survey questionnaires. The discussion here and under d, below, is intended as a guide to the selection, organization, and wording of survey questions.

1. See Leon Festinger and Daniel Katz, eds., Research Methods in the Behavioral Sciences (New York: Holt, Rinehart and Winston, 1953), pp. 340-353; Claire Sellitz, Marie Johoda, Morton Deutsch, and Stuart W. Cook, Research Methods in Social Relations (New York: Holt, Rinehart and Winston, 1959), pp. 255-263.

The questionnaire should be mostly "closed-end"--designed so that soldiers can check off their responses rather than writing them. Many people find it difficult to express themselves, and most find it distasteful to have to write and telescope their thoughts sufficiently for clarity. (For instance, the question "How did you happen to try that drug?" is likely to be answered "Was with friends" rather than "Friends were doing it and I wanted to join them.") Also, checked-off responses make computer entry and interpretation much easier. Space can be left at the end to allow soldiers to write in any comments they might have and those checking an "other" category should be asked to specify what the "other" is; the rest of the questionnaire should be closed-end.

Questions should follow a logical pattern so the train of thought is easy to follow. Generally speaking, questions should be in a "funnel" order--going from general to more specific. Sensitive questions should not be placed at the very beginning of the questionnaire. In changing topics, a transitional sentence helps--e.g., "Now, a few questions about yourself."

Language should be simple and easily understood. Since people often have different frames of reference for words, care should be taken to define any such words which are going to be used. An example is the term "drug education." Many schools give some sort of "drug education," so it must be understood that the term relates to Army Drug Education. Also, drug education can take many forms, from formal programs to "raps" with other soldiers and staff. Thus, the exact context in which respondents are to consider the term "drug education" must be spelled out.

Questions should be asked in such a manner that all answers are seen as equally probable. While this is most critical in an interview, it also holds true for a questionnaire, since respondents do pick up subtle clues as to what answers are expected and may bias their responses accordingly. For example, instead of asking "Do you think someone caught using drugs should be dishonorably discharged from the Army," one might say, "Some people have said that a person caught using drugs should be dishonorably discharged from the Army. Do you agree, disagree, have no opinion, or think it depends on the circumstances?"

The instrument should be precoded to simplify the process of computing the data. Two types of response can be used with a precoded questionnaire: (1) mark sensing where the respondent fills in the square or circle representing his/her answer and (2) keypunch-ready questionnaires where columns are assigned to each question, responses are numbered, and the box is checked. Examples of each are shown below.

Mark sense

What is your marital status? (Mark only one)

- Married
- Legally separated
- Divorced
- Widowed
- Never married (single)

Keypunch

What is your marital status? (Check only one)

1. Married

(13)

2. Legally separated

3. Divorced

4. Widowed

5. Never married (single)

Mark sensing requires more attention on the part of the respondent (to erase rather than cross out responses which are changed, to use a particular kind of writing instrument, and to avoid making stray marks near the responses, but eliminates the need to keypunch the data--an additional step in which errors could be introduced.

Whichever type of questionnaire is used, the layout should look clean and uncluttered, and should be easy to follow. It is advisable to use two kinds of type, such as roman and italic--one for questions and one for instructions. Unless a question takes up no more than a full page, it should not be split up between two pages.

It is often useful to make consistency checks and order-bias checks. The former consist of checks to make sure responses are consistent throughout the questionnaire. For example, one can ask about drug use in one place and then later ask questions relying on the earlier data. Thus, question 10 might ask about specific experience with various kinds of drugs, and question 41 might ask, "For each drug you have ever tried, please indicate whether or not you presently use that drug," and might include the possible response "does not apply--never used." Responses

to questions 10 and 41 can then be compared for consistency.

Inconsistent responses are a reminder that the survey results, while valuable, do not necessarily represent gospel truth in all cases.

Respondent bias refers to the fact that fatigue and other factors such as a tendency to agree with statements consistently may work against a correct response. To avoid this, questions which ask for agree-disagree type responses, for example, can be divided between positively worded and negatively worded statements.

For sensitive questions, sanctioning statements help to ease socially unacceptable responses. A classic example is in questions about voting, where rather than asking "Did you vote in the last election?" one might say, "Many people didn't get a chance to go to the polls in the last election. Did you happen to go to the polls, or not?" In some instances the issue may be sufficiently sensitive that it needs to be asked in the third rather than the first person (since people tend to project their own feelings on others). For example, rather than asking "Would you go back into treatment/rehabilitation?" one can ask, "On the basis of your experience in treatment/rehabilitation, would you recommend the program to a friend or not?"

Responses should include large enough intervals so that respondents feel "protected"; for example, income should generally not be grouped in \$1000 intervals. Also, in questions about income and education no one wants to be in the lowest group, so the first grouping should be low enough to exclude nearly everyone (for example, income under \$3000).

The questionnaire needs an introduction and a set of instructions.

The former gives information about why the survey is being conducted and what will be done with the data (stressing anonymity). The latter informs the respondent about how to proceed.

The questionnaire is typically in booklet form, printed on both sides of the page.

d. Types of Question

Several types of question can be asked. These include factual background questions (age, length of service, marital status, income, etc.), behavioral questions (types of drugs used, amount of alcohol consumed, frequency of use/consumption, etc.), attitudinal questions (attitudes toward drug/alcohol programs and personnel, attitudes of others toward them, etc.), and knowledge questions (how well-informed respondent is regarding drug/alcohol side-effects, what respondent has learned from a given program or experience, etc.).

There are a number of ways of asking questions, particularly attitudinal ones. Many techniques are available, from agree/disagree scales to the semantic differential, which asks respondents to place themselves along a spectrum bounded by extreme opinions, for instance:

Attitudes toward drug use here at this post are:

Strong _____ weak

Users should be punished _____ users
should not be punished

Etc.

In the spectrum type of question it is a good idea to have enough response choices (for instance, 5 rather than 3) so that respondents can express an opinion without being at the extreme end of the scale. Whole books and chapters are devoted to the measurement of attitudes, and anyone designing a questionnaire for this purpose would do well to review some of that material.¹

e. The Pretest

Before a questionnaire (including one of the sample questionnaires presented here) is administered to a respondent sample, it should be tested with a small number (5-10) of respondents in each group (known substance abusers, potential abusers, leaders) under the actual conditions of the survey. At the conclusion, the staff member administering the questionnaire should review the questions with each respondent, asking him to point out questions that were confusing or response categories that were confusing, misleading, or inappropriate. The questionnaires can then be revised, printed, and made ready for the survey.

4. WHAT TO DO WITH THE DATA

a. Checking and Correcting the Data

The first step after the questionnaires have been filled out is to number them. Then they need to be edited to make sure that there are no double answers where single answers were required. When this occurs in a list

1. See, for example, John P. Robinson and Phillip R. Shauer, Measures of Social Psychological Attitude (Ann Arbor: Survey Research Center, University of Michigan, 1969). Also Sellitz, op. cit., pp. 243-55; 279-314; 343-384.

of responses, the higher numbered response should generally be used; for example, if response 2 and response 5 are both checked, response 5 should be chosen. If the answers are conflicting (e.g., "yes" and "no"), the next question should be reviewed to see if it indicates which is right. If not, the question is left blank. Mark sense questionnaires also need checking to see that there are no stray marks or crossouts on the sheet which will affect reading of the questionnaire. Keypunch questionnaires must be keypunched to cards or directly to tape and mark-sense "read" onto tape. A computer "edit" is run to check for wild codes, etc., and cards or questionnaires with problems are pulled and corrected.

b. Tabulating Responses

"Straight tabulations" (also called distributions or marginals) can then be run, showing the number and percent of respondents checking each response item. These show the distribution of responses to any given questions. Where the distribution is heavily skewed so that people generally respond the same, there is no point in proceeding to run cross-tabulations; however, for those with a more balanced distribution, cross-tabulations can reveal whether or not differences in other variables (such as pay grade, length of time at the post, etc.) are associated with these different responses.

Cross-tabulations can be of several types, including responses by background data (e.g., age, marital status, etc.), consistency checks (responses to one question by response to another), cross-tabulations of one attitude against another, cross-tabulations of attitudes against behavior.

Table D-1 shows examples of each of these.

TABLE D-1
FOUR TYPES OF CROSS-TABULATION

1. Response by Background Data

Whether or not do not use drugs
because of fear of getting caught, by sex

<u>Do not use from fear</u>	<u>Sex</u>	
	<u>Male</u>	<u>Female</u>
Yes	x	x
No	x	x

2. Consistency Check

Whether response to Q1 is consistent
with response to Q3

(would be done for each drug and for alcohol)

<u>Never used checked?</u>	<u>Stay zero checked?</u>	
	<u>Yes</u>	<u>No</u>
Yes	x	x
No	x	x

3. One Attitude vs. Another

For those stopping, influences on stopping drugs/drinking too much
by most important reasons for using

(This table would only be possible with large sample sizes)

<u>Influence on Stopping</u>	<u>Good time</u>	<u>how feels</u>	<u>Bored</u>	<u>Cope</u>	<u>Available, cheap</u>	<u>Like getting high</u>	<u>Helps relax</u>	<u>Helps stay awake</u>	<u>Something to do</u>
Fear of being caught									
Fear of becoming addicted									
Fear of job failure									
Counseling/rehab.									
Drinking age									
Spouse/friend									
Education									
Not available									
Too expensive									
Busted									
Just decided									
Didn't like									
Religion									
Other									

TABLE D-1 (Continued)

4. Attitudes versus Behavior

For those using, reasons for using drugs
on post by whether or not use only on weekends

<u>Reasons for using</u>	<u>Use one or more only on weekends</u>	<u>Don't use any only on weekends (use any time during the week)</u>
Good time		
Like how it feels		
Bored		
Cope with Army life		
Available, cheap		
Like getting high		
Helps me relax		
Helps me stay awake		
Something to do		

The statistical work should be conducted with a set of questions to be answered. Examples of such questions are given in Form D-3 at the end of this appendix.

c. Interpreting the Results

Once the data have been tabulated in terms of frequency counts and cross-tabulations, it remains to analyze the data; that is, interpret the results by applying statistical estimation and testing techniques which lead to valid conclusions about the population group from which the sample has been taken. The objective of the analysis is to gain insight into the drug and alcohol problem in order to develop or improve programs aimed at correcting it. The survey helps to show how drug use and problem drinking are related to knowledge, attitudes, and background characteristics of the population surveyed. Before inferences can be drawn from the survey, however, it is necessary to determine the statistical significance of the observed relationships between variables in the cross-tabulations. That is, it is necessary to determine whether variables (such as age and drug use) are independent of one another or whether they are related.

An effective technique for determining statistical significance is provided by the Chi-square (χ^2) test.¹ In this application, the Chi-square (χ^2) test statistic is used to determine whether two variables are statistically independent. An example similar to the cross-tabulation examples above is used here to demonstrate the Chi-square technique. The explana-

1. For a discussion of theory, see Barnard Ostle, Statistics in Research (Ames, Iowa: Iowa State College Press, 1956).

tion is intended to be understood by a reader who has some mathematical background but not statistics. If the ADAPCP has access to someone with a statistical background, however, it is simpler to have that person handle the data analysis with guidance from the ADCO as to the information sought.

Suppose that program staff wish to determine whether there is a relationship between drug use and age and that 1000 soldiers from the combined known and potential substance abuser groups have been randomly selected and tested. From questionnaire results, the contingency table (cross-tabulation) shown in Table D-2 could be constructed. Each of the boxes in this table where a value has been entered is called a "cell." (If a cell's frequency count is less than 5, it is combined with an adjacent cell to create a broader class.)

At a glance it appears from Table D-2 that there is a relationship between drug use and age; younger soldiers appear to use drugs more heavily than older soldiers. However, to confirm that there is a dependency between the variables (age, drug use), it is necessary to develop the appropriate test statistic in order to establish one of two possible inferences:

- I₁: Age and drug use are statistically independent, or
- I₂: Age and drug use are not statistically independent (that is, they are strongly related, since a relationship that is only slight will show up as "independent" in the calculations).

TABLE D-2
CONTINGENCY TABLE SHOWING AGE VERSUS DRUG USE
Sample of 1000 Soldiers

Drug Use	Age			TOTAL
	(B ₁)	(B ₂)	(B ₃)	
TOTAL	17-20	21-25	26+	
(A ₁) Drug Users	205	80	15	300
(A ₂) Non-Users	395	220	85	700
	600	300	100	1000

A step-by-step procedure for calculating the test statistic follows.

Note that the values in each cell of the contingency table are the actual sample counts of drug use/non-use relative to age. In the calculations which follow, estimates are made of the expected counts, or frequencies, if, in fact, conclusion I₁ is true; that is, age and drug use are independent.

Step 1: Compute the expected frequencies for each cell in the table by multiplying a cell's row total by its column total and dividing by the sample (grand) total.

For example, the expected frequency of the cell containing drug users who are 17-20 years old (A₁, B₁) is computed as follows:

$$\frac{(300)(600)}{1000} = 180$$

Step 2: Insert the expected frequency in each cell along with the actual count. Circle the expected frequencies.

Drug Use	Age			TOTAL
	17-20	21-25	26+	
Drug Users	205 (180)	80 (90)	15 (30)	300
Non-Users	395 (420)	220 (210)	85 (70)	700
TOTAL	600	300	100	1000

Step 3: Calculate the test statistic (V) using the "Calculation of Test Statistic for Statistical Independence" shown in Table D-3.

TABLE D-3

CALCULATION OF TEST STATISTIC
FOR STATISTICAL INDEPENDENCE*

Joint Classification	Sample Count (f_s)	Expected Frequency (f_e)	Deviation ($f_s - f_e$)	Squared Deviation ($(f_s - f_e)^2$)	Relative Squared Deviation $\frac{(f_s - f_e)^2}{f_e}$
A ₁ and B ₁	205	180	+25	625	3.472
A ₁ and B ₂	80	90	-10	100	1.111
A ₁ and B ₃	15	30	-15	225	7.500
A ₂ and B ₁	395	420	-25	625	1.488
A ₂ and B ₂	220	210	+10	100	0.476
A ₂ and B ₃	<u>85</u>	<u>70</u>	<u>+15</u>	<u>225</u>	<u>3.214</u>
	1000	1000	0		V = 17.261**

* Entries in first 3 columns are from Table D-2; the rest are calculated from these.

** The formula for this calculation reads

$$V = \sum \frac{(f_s - f_e)^2}{f_e} = 17.261 \text{ (\Sigma means "the sum of").}$$

Step 4: Compare the test statistic (V) to a Chi-square (χ^2) distribution with $(R-1) \times (C-1)$ degrees of freedom. As explained below, R and C refer to the number of rows and columns in the contingency table, D-2. Chi-square (χ^2) distributions are shown in Table D-4. The theory of this analysis will not be detailed here. It is sufficient for present purposes to say that statistical theory shows that for the type of problem under consideration, if I_1 is true (that is, if age and drug use are independent), the test statistic (V) will be equal to or less than a Chi-square distribution with $(R-1)(C-1)$ degrees of freedom, where,

R = the number of classes (rows) into which one of the variables is classified;

C = the number of classes (columns) of the other variable.

To conclude this step it is necessary to:

- a. Compute the degrees of freedom, $(R-1)(C-1)$. The contingency table has two rows and three columns, so $R=2$ and $C=3$. Thus,
$$(R-1)(C-1) = (2-1)(3-1) = 2.$$
- b. Determine the acceptable level of risk that the conclusion will be erroneous. The usual practice is to tolerate a risk (or chance of error) of .05. This means that the chance is only 1 in 20 that the calculation will show I_2 to be correct when in fact I_1 is correct; that is, the chance is only 1 in 20 that the two variables will appear to have a statistically significant relationship when they are really independent. Note that the Chi-square (χ^2) distribution table, Table D-4, displays risk levels of .01 (1 in 100), .02 (2 in 100), .05 (1 in 20), .10 (1 in 10). In this discussion, the conventional one, .05, is used.

TABLE D-4
TABLE OF χ^2 DISTRIBUTION

<u>Degrees of Freedom</u>	<u>Risk Levels</u>			
	.10	.05	.02	.01
1	2.706	3.841	5.412	6.635
2	4.605	5.991	7.824	9.210
3	6.251	7.815	9.837	11.341
4	7.779	9.488	11.668	13.277
5	9.236	11.070	13.388	15.086
6	10.645	12.592	15.033	16.812
7	12.017	14.067	16.622	18.475
8	13.362	15.507	18.168	20.090
9	14.684	16.919	19.679	21.666
10	15.987	18.307	21.161	23.209
11	17.275	19.675	22.618	24.725
12	18.549	21.026	24.054	26.217
13	19.812	22.362	25.472	27.688
14	21.064	23.685	26.873	29.141
15	22.307	24.996	28.259	30.578
16	23.542	26.296	29.633	32.000
17	24.769	27.587	30.995	33.409
18	25.989	28.869	32.346	34.805
19	27.204	30.144	33.687	36.191
20	28.412	31.410	35.020	37.566
21	29.615	32.671	36.343	38.932
22	30.813	33.924	37.659	40.289
23	32.007	35.172	38.968	41.638
24	33.196	36.415	40.270	42.980
25	34.382	37.652	41.566	44.314
26	35.563	38.885	42.856	45.642
27	36.741	40.113	44.140	46.963
28	37.916	41.337	45.419	48.278
29	39.087	42.557	46.693	49.588
30	40.256	43.773	47.962	50.892

From R. A. Fisher, Statistical Methods for Research Workers
(Edinburgh: Oliver and Boyd, 1934-1944).

c. Read the Chi-square value from the table using the appropriate degrees of freedom (in this case 2) and an assumed .05 risk of error. In this example, the tabular $\chi^2 = 5.991$.

d. Set up a decision rule as follows:

If $V \leq 5.991$, conclude I_1 (age and drug use are independent).

If $V > 5.991$, conclude I_2 (age and drug use are not independent; that is, the data indicate a strong relationship).

In the example $V = 17.261$. This shows that age and drug use are not independent (I_2). Note by looking at Table D-4 that one would reach the same conclusion by running the risk of being in error only 1 in 100 times; in other words, the computed V statistic could be expected to be 9.210 or larger less than 1% of the time if, in fact, rows and columns were independent.

Since this is so unlikely, one can conclude that the alternative (I_2) holds.

This means that there is a statistically significant relationship between age and drug use in the population from which the survey sample has been drawn. Drug use is more heavily concentrated in the younger age group, and if programs to prevent drug use are to be aimed at particular age groups, the younger groups should receive higher priority than the older.

5. SAMPLE SURVEY QUESTIONNAIRES

Forms D-1 and D-2, which follow, are sample questionnaires for use with actual and potential substance abusers (D-1) and with the leadership structure (D-2). As noted earlier, they can be modified to suit the requirements of each post.

FORM D-1

SAMPLE QUESTIONNAIRE FOR POTENTIAL OR KNOWN DRUG USERS AND PROBLEM DRINKERS:

KEYPUNCH VERSION¹

DRUG AND ALCOHOL SURVEY

WHAT THIS IS ABOUT

We are trying to find out about the use of drugs and alcohol at this post. You are one of about ____ soldiers filling out this survey.

This questionnaire is for you to fill out anonymously. You cannot be identified, because you are asked not to sign your name. DO NOT SIGN YOUR NAME OR SOCIAL SECURITY NUMBER ANYWHERE ON THE QUESTIONNAIRE.

This survey is not for or against drugs and alcohol. Its only purpose is to get facts, opinions, and attitudes about drugs and alcohol. Unless the question asks otherwise, when we speak of drug use we are talking about drug use without a prescription.

Your honest answers to this survey will help soldiers who have alcohol or drug problems, now and in the future. Facts learned from this survey

1. For mark sense version, the following instructions can be added under WHAT TO DO:

Marking Directions: Your responses will be read by an optical mark reader. Your careful observance of these few simple rules will be most appreciated:

- Use only the black lead pencil you have been given.
- Make heavy black marks that fill the circle.
- Erase cleanly any answer you wish to change.
- Make no stray markings of any kind.

Example: 1. Are marks made in black pencil the only type the optical reader will recognize?

- Yes
- No

FORM D-1 (Continued)

will help the post to develop better programs of alcohol and drug education.

Instructions for answering these questions are below. Read them carefully before you begin.

Thanks. We appreciate your help.

WHAT TO DO

You can answer most of the questions below by making a check mark.

Ignore the numbers in italics. They are for computer use only. Make one answer to each question, unless the question says, "Check as many as apply." In a few questions, we ask you to explain or specify an answer or fill in a number. Answer all the questions honestly and carefully. There is no time limit, so take as much time as you need.

Questionnaire No. (1) (2) (3) (4)

First, we'd like to ask a few questions about you:

1. Are you male or female? (Please check one)

1. male 2. female (5)

2. How old were you on your last birthday (Please check one)

1. 18 or less 4. 23-25 (6)

2. 19-20 5. 26-29

3. 21-22 6. 30 or more

3. Which one of the following do you consider yourself
(Please check one)

1. Spanish/Mexican American (7)

2. White (other than Spanish/Mexican American)

3. Black

4. Other (Oriental, American Indian, etc.)

FORM D-1 (Continued)

4. What is your marital status? (Please check one)

- | | | |
|---|---|-----|
| <input type="checkbox"/> 1. Married | <input type="checkbox"/> 4. Widowed | (8) |
| <input type="checkbox"/> 2. Legally separated | <input type="checkbox"/> 5. Never married | |
| <input type="checkbox"/> 3. Divorced | (single) | |

5. What is your highest level of education, including accepted GED credits? (Please check one)

- | | |
|--|-----|
| <input type="checkbox"/> 1. Grammar school | (9) |
| <input type="checkbox"/> 2. Some high school | |
| <input type="checkbox"/> 3. GED (high school equivalent) | |
| <input type="checkbox"/> 4. High school graduate (diploma) | |
| <input type="checkbox"/> 5. Post high school trade/technical school (no college) | |
| <input type="checkbox"/> 6. 1-3 years college | |
| <input type="checkbox"/> 7. 4 years college/degree | |
| <input type="checkbox"/> 8. Some graduate work | |
| <input type="checkbox"/> 9. graduate degree (masters, doctorate) | |

6. Where did you live just before going into the Army? (Please check one)

- | | |
|--|------|
| <input type="checkbox"/> 1. A farm/ranch | (10) |
| <input type="checkbox"/> 2. In the country but <u>not</u> a farm/ranch | |
| <input type="checkbox"/> 3. Town/small city (less than 25,000 people then) | |
| <input type="checkbox"/> 4. Medium city (25,000-100,000 people then) | |
| <input type="checkbox"/> 5. Large city (<u>over</u> 100,000 people then) | |
| <input type="checkbox"/> 6. Suburb of a large city | |
| <input type="checkbox"/> 7. Suburb of a small/medium city | |

FORM D-1 (Continued)

7. What is your present military pay grade?
(Please check one)

1. E-1 4. E-4 7. E-7 (11)
 2. E-2 5. E-5 8. E-8
 3. E-3 6. E-6 9. E-9

8. What is your present Army status? (Please check one)

1. Regular Army 2. Reservist (12)

9. What kind of unit are you in? (Please check one)

1. Combat Arms [for example, Infantry, (13)

Airborne, Field Artillery, Air Defense

Artillery, Armor, Cavalry, Special Forces

Engineering Units designated as combat
arm units]

2. Combat Support Arms [for example, Signal
Corps, Military Police, Aviation, Chemical
Corps, Transportation (Direct Support),
Ordnance, Engineers not designated as
combat arm units]

3. Combat Service Support Arms [for example,
Quartermaster, Judge Advocate General, Finance,
Medical, Dental, Adjutant General, Military
Intelligence, Chaplain, Women's Army Corps,
Transportation (General Support)]

10. Do you live on or off this post? (Please check one)

1. On the post 2. Off the post (14)

FORM D-1 (Continued)

11. How long have you been assigned to this post?
(Please check one)

(15)

- 1. Less than 6 months
- 2. 6-12 months
- 3. Over 1 year to 2 years
- 4. Over 2 years to 3 years
- 5. Over 3 years to 4 years
- 6. Over 4 years

12. How long have you been in the Army? *(Please check one)*

- | | | |
|--|---|------|
| <input type="checkbox"/> 1. Less than 6 months | <input type="checkbox"/> 5. Over 3 years to 4 years | (16) |
| <input type="checkbox"/> 2. 6-12 months | <input type="checkbox"/> 6. 5-8 years | |
| <input type="checkbox"/> 3. Over 1 year
to 2 years | <input type="checkbox"/> 7. 9-12 years | |
| <input type="checkbox"/> 4. Over 2 years
to 3 years | <input type="checkbox"/> 8. 13-20 years | |
| | <input type="checkbox"/> 9. Over 20 years | |

13. Do you plan on making the Army your career or not?
(Please check one)

- 1. Yes
- 2. No
- 3. Don't know

(17)

FORM D-1 (Continued)

We'd like to get your opinions about the extent of drug use and heavy drinking on this post. First, we will give you a few definitions of terms:

<u>Substance</u>	<u>Examples</u>
Marijuana/hash.....	Pot, grass, hash, etc.
Hallucinogens.....	LSD, mescaline, peyote, STP, DOM, THC, Sernyl, PCP, etc.
Amphetamines.....	Benzedrine, Methedrine, Ritalin, speed, Dexedrine, crystal, etc.
Cocaine.....	C, coke, dust, snow
Other uppers.....	Preludin, any stimulant other than cocaine and amphetamines
Barbiturates.....	Seconal, Nembutal, Amytal, "reds," "yellow," etc.
Other downers.....	Doriden, Mandrax, Quaalude, Sopors, etc.
Darvon.....	Darvon
Methadone.....	Dollies, dolls
Other opiates.....	Heroin, morphine, opium, Demerol, codeine

FORM D-1 (Continued)

"Unit" in this questionnaire means "company."

1. For each item listed below, please check your estimate of the percent of the people in your unit who are currently using the drug or drinking more than is good for them. (Check one for each)

	No one (0%)	1-5%	6-10%	11-25%	26-50%	51-75%	76-100%	Don't know
Marijuana/hash	1.	2.	3.	4.	5.	6.	7.	8. (18)
Hallucinogens	1.	2.	3.	4.	5.	6.	7.	8. (19)
Amphetamines	1.	2.	3.	4.	5.	6.	7.	8. (20)
Cocaine	1.	2.	3.	4.	5.	6.	7.	8. (21)
Other uppers	1.	2.	3.	4.	5.	6.	7.	8. (22)
Barbiturates	1.	2.	3.	4.	5.	6.	7.	8. (23)
Other downers	1.	2.	3.	4.	5.	6.	7.	8. (24)
Darvon	1.	2.	3.	4.	5.	6.	7.	8. (25)
Methadone	1.	2.	3.	4.	5.	6.	7.	8. (26)
Other opiates	1.	2.	3.	4.	5.	6.	7.	8. (27)
Drinking more	1.	2.	3.	4.	5.	6.	7.	8. (28)

than is good for them

FORM D-1 (Continued)

2. What percent of people in your unit do you think are using each drug or drinking more than is good for them on the job? (Please check one for each)

	No one (0%)	1-5%	6-10%	11-25%	26-50%	51-75%	76-100%	Don't know
Marijuana/hash	1.	2.	3.	4.	5.	6.	7.	8. (29)
Hallucinogens	1.	2.	3.	4.	5.	6.	7.	8. (30)
Amphetamines	1.	2.	3.	4.	5.	6.	7.	8. (31)
Cocaine	1.	2.	3.	4.	5.	6.	7.	8. (32)
Other uppers	1.	2.	3.	4.	5.	6.	7.	8. (33)
Barbiturates	1.	2.	3.	4.	5.	6.	7.	8. (34)
Other downers	1.	2.	3.	4.	5.	6.	7.	8. (35)
Darvon	1.	2.	3.	4.	5.	6.	7.	8. (36)
Methadone	1.	2.	3.	4.	5.	6.	7.	8. (37)
Other opiates	1.	2.	3.	4.	5.	6.	7.	8. (38)
Drinking more	1.	2.	3.	4.	5.	6.	7.	8. (39)

than is good for them

FORM D-1 (Continued)

3. Which of the following drugs can be easily obtained
in the community around this post?

(Check as many as apply) (40)

- | | |
|--|---|
| <input type="checkbox"/> 1. None | <input type="checkbox"/> 7. Barbiturates |
| <input type="checkbox"/> 2. Marijuana/hash | <input type="checkbox"/> 8. Other downers |
| <input type="checkbox"/> 3. Hallucinogens | <input type="checkbox"/> 9. Darvon |
| <input type="checkbox"/> 4. Amphetamines | <input type="checkbox"/> 0. Methadone |
| <input type="checkbox"/> 5. Cocaine | <input type="checkbox"/> X. Other opiates |
| <input type="checkbox"/> 6. Other uppers | <input type="checkbox"/> Y. Don't know |

4. Which of the following drugs can be easily obtained
on this post? (Check as many as apply) (41)

- | | |
|--|---|
| <input type="checkbox"/> 1. None | <input type="checkbox"/> 7. Barbiturates |
| <input type="checkbox"/> 2. Marijuana/hash | <input type="checkbox"/> 8. Other downers |
| <input type="checkbox"/> 3. Hallucinogens | <input type="checkbox"/> 9. Darvon |
| <input type="checkbox"/> 4. Amphetamines | <input type="checkbox"/> 0. Methadone |
| <input type="checkbox"/> 5. Cocaine | <input type="checkbox"/> X. Other opiates |
| <input type="checkbox"/> 6. Other uppers | <input type="checkbox"/> Y. Don't know |

FORM D-1 (Continued)

5. Generally speaking, what do you think is the attitude of your commanding officer toward people using drugs and drinking more than is good for them?

(Check as many as apply for each type)

	<u>Marijuana/hash</u>	<u>Other drugs</u>	<u>Drinking more than is good</u>
Thinks it's OK	1. (42)	1. (43)	1. (44)
Thinks it's OK as long as you don't get caught	2.	2.	2.
Thinks it's OK <u>off duty</u>	3.	3.	3.
Doesn't like at all	4.	4.	4.
Thinks person should be punished	5.	5.	5.
Thinks it's illegal	6.	6.	6.
Thinks person should be transferred	7.	7.	7.
Thinks person should be discharged	8.	8.	8.
Thinks person needs help	9.	9.	9.
Thinks person should get help	0.	0.	0.
Doesn't care	X.	X.	X.
Don't know	Y.	Y.	Y.

FORM D-1 (Continued)

6. What are your own personal feelings about people using drugs and drinking more than is good for them?

(Check as many as apply for each type)

	<u>Marijuana/hash</u>	<u>Other drugs</u>	<u>Drinking more than is good</u>
It's OK	—1. (45)	—1. (46)	—1. (47)
It's OK as long as you don't get caught	—2.	—2.	—2.
It's OK <u>off duty</u>	—3.	—3.	—3.
Don't like at all	—4.	—4.	—4.
Person should be punished	—5.	—5.	—5.
It's illegal	—6.	—6.	—6.
Person should be transferred	—7.	—7.	—7.
Person should be discharged	—8.	—8.	—8.
Person needs help	—9.	—9.	—9.
Person should get help	—0.	—0.	—0.
Don't care	—X.	—X.	—X.
Don't know	—Y.	—Y.	—Y.

We would like to turn now to your own personal use of drugs and alcohol.

FORM D-1 (Continued)

1. For each substance (item) below, please check whether or not you have ever used (or done) it. (Check one for each line)

	<u>Have used/done it</u>	<u>Have never used/done it</u>
Drinking too heavily	____ 1.	____ 2. (48)
Marijuana/hash	____ 1.	____ 2. (49)
Hallucinogens	____ 1.	____ 2. (50)
Amphetamines	____ 1.	____ 2. (51)
Cocaine	____ 1.	____ 2. (52)
Other uppers	____ 1.	____ 2. (53)
Barbiturates	____ 1.	____ 2. (54)
Other downers	____ 1.	____ 2. (55)
Darvon	____ 1.	____ 2. (56)
Methadone	____ 1.	____ 2. (57)
Other opiates	____ 1.	____ 2. (58)

2. For each substance (item) below, please check whether or not you ever used (or did) it before entering the Army. (Check one for each line)

	<u>Used/did it before entering Army</u>	<u>Never used/did before entering Army</u>
Drinking too heavily	____ 1.	____ 2. (59)
Marijuana/hash	____ 1.	____ 2. (60)
Hallucinogens	____ 1.	____ 2. (61)
Amphetamines	____ 1.	____ 2. (62)
Cocaine	____ 1.	____ 2. (63)
Other uppers	____ 1.	____ 2. (64)
Barbiturates	____ 1.	____ 2. (65)
Other downers	____ 1.	____ 2. (66)
Darvon	____ 1.	____ 2. (67)
Methadone	____ 1.	____ 2. (68)
Other opiates	____ 1.	____ 2. (69)

End of Card 1 $\frac{1}{80}$

Questionnaire No.

FORM D-1 (Continued)

3. For each substance (item) below, please check whether or not you have used (done) it at this post. (Check one for each line)

	<u>Used/did it at this post</u>	<u>Never used/did it at this post</u>	
Drinking too heavily	— 1.	— 2.	(5)
Marijuana/hash	— 1.	— 2.	(6)
Hallucinogens	— 1.	— 2.	(7)
Amphetamines	— 1.	— 2.	(8)
Cocaine	— 1.	— 2.	(9)
Other uppers	— 1.	— 2.	(10)
Barbiturates	— 1.	— 2.	(11)
Other downers	— 1.	— 2.	(12)
Darvon	— 1.	— 2.	(13)
Methadone	— 1.	— 2.	(14)
Other opiates	— 1.	— 2.	(15)

FORM D-1 (Continued)

4. What would you say are the most important reasons you started using marijuana? (Check as many as apply)

- 1. Doesn't apply--I've never used marijuana (16)
- 2. My friends were using it and I wanted to join them
- 3. I had never tried it before and wanted to
- 4. I liked the way it made me feel
- 5. I was bored
- 6. I thought it would be a new "kick"
- 7. I was having trouble in the Army and thought it would help me through a rough period
- 8. It was easily available and cheap
- 9. I like to get high
- 10. It helped me relax, calm my nerves, or sleep
- X. It helped me stay awake, helped my performance
- Y. To have a good time with my friends

5. What would you say are the most important reasons you started using drugs other than marijuana? (Check as many as apply)

- 1. Doesn't apply--I've never used those drugs (17)
- 2. My friends were using them and I wanted to join them
- 3. I had never tried them before and wanted to
- 4. I liked the way they made me feel
- 5. I was bored
- 6. I thought they would be a new "kick"
- 7. I was having trouble in the Army and thought they would help me through a rough period
- 8. They were easily available and cheap
- 9. I like to get high
- 10. They helped me relax, calm my nerves, or sleep
- X. They helped me stay awake, helped my performance
- Y. To have a good time with my friends

FORM D-1 (Continued)

6. What would you say are the most important reasons you started drinking more than is good for you? (Check as many as apply)

- 1. Doesn't apply--I've never drunk more than was good for me (18)
- 2. My friends were doing it and I wanted to join them
- 3. I had never done it before and wanted to
- 4. I liked the way it made me feel
- 5. I was bored
- 6. I thought it would be a new "kick"
- 7. I was having trouble in the Army and thought it would help me through a rough period
- 8. Alcohol was easily available and cheap
- 9. I like to get high
- 0. It helped me relax, calm my nerves, or sleep
- X. It helped me stay awake, helped my performance
- Y. To have a good time with my friends

FORM D-1 (Continued)

7. Since you came to this post, would you say your use of these drugs/heavy drinking has started (I didn't do it before, but I do now); increased (I do it more now; stayed the same (I do it the same as before); stayed zero (I didn't do it before and don't do it now); decreased (I do it less now); or stopped (I did it before but don't now)? (Please make one check for each line)

	<u>Started</u>	<u>Increased</u>	<u>Stayed Same</u>	<u>Stayed Zero</u>	<u>Decreased</u>	<u>Stopped</u>	
Drinking too heavily	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(19)
Marijuana/hash	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(20)
Hallucinogens	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(21)
Amphetamines	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(22)
Cocaine	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(23)
Other uppers	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(24)
Barbiturates	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(25)
Other downers	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(26)
Darvon	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(27)
Methadone	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(28)
Other opiates	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(29)

FORM D-1 (Continued)

8. What are your most important reasons for using marijuana
on this post? (Check as many as apply)

1. Doesn't apply--I have never used marijuana (30)
on this post at all
2. To have a good time with my friends
3. I like the way it makes me feel
4. I am bored
5. It helps me cope with Army life
6. It is available and cheap
7. I like to get high
8. It helps me relax/calms my nerves/helps me sleep
9. It helps me stay awake/helps my performance
0. It's something to do

9. What are your most important reasons for using drugs other
than marijuana on this post? (Check as many as apply)

1. Doesn't apply--I have never used those drugs (31)
on this post at all
2. To have a good time with my friends
3. I like the way they make me feel
4. I am bored
5. They help me cope with Army life
6. They are available and cheap
7. I like to get high
8. They help me relax/calm my nerves/help me sleep
9. They help me stay awake/help my performance
0. It's something to do

FORM D-1 (Continued)

10. What are your most important reasons for drinking
more than is good for you on this post?

(Check as many as apply)

- 1. Doesn't apply--I have never drunk more than
is good for me on this post/at all (32)
- 2. To have a good time with my friends
- 3. I like the way it makes me feel
- 4. I am bored
- 5. It helps me cope with Army life
- 6. Alcohol is available and cheap
- 7. I like to get high
- 8. It helps me relax/calms my nerves/helps me sleep
- 9. It helps me stay awake/helps my performance
- 0. It's something to do

FORM D-1 (Continued)

11. On how many days during the last 30 days if any, did you use (or do) each of the following?

(For instance, if you used marijuana/hash 6 days, check the line under column headed (3-6 days). Fill out one line at a time. Check one for each substance.)

	<u>None</u>	<u>1-2 Days</u>	<u>3-6 Days</u>	<u>7-14 Days</u>	<u>15-29 Days</u>	<u>30 Days</u>	
Drink too heavily	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(33)
Marijuana/hash	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(34)
Hallucinogens	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(35)
Amphetamines	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(36)
Cocaine	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(37)
Other uppers	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(38)
Barbiturates	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(39)
Other downers	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(40)
Darvon	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(41)
Methadone	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(42)
Other opiates	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(43)

FORM D-1 (Continued)

12. Which, if any, of the following do you use (do) only on weekends? (*Check as many as apply*)

- 1. Doesn't apply--don't use drugs or drink too heavily at all (44)
- 2. Doesn't apply--don't use (do) any just on weekends
- 3. Drink too heavily
- 4. Marijuana/hash
- 5. Hallucinogens
- 6. Amphetamines
- 7. Cocaine
- 8. Other uppers
- 9. Barbiturates
- 1. Other downers (45)
- 2. Darvon
- 3. Methadone
- 4. Other opiates

FORM D-1 (Continued)

13. For each substance (item) below, please check whether you usually use (do) it alone, with one or two others, or with 3 people or more. If you don't use (do) it, check "Don't use (do) it." (Check one for each item)

	<u>Alone</u>	<u>With 1-2 others</u>	<u>With 3 or more</u>	<u>Don't use (do) it</u>	
Drinking too heavily	—1.	—2.	—3.	—4.	(46)
Marijuana/hash	—1.	—2.	—3.	—4.	(47)
Hallucinogens	—1.	—2.	—3.	—4.	(48)
Amphetamines	—1.	—2.	—3.	—4.	(49)
Cocaine	—1.	—2.	—3.	—4.	(50)
Other uppers	—1.	—2.	—3.	—4.	(51)
Barbiturates	—1.	—2.	—3.	—4.	(52)
Other downers	—1.	—2.	—3.	—4.	(53)
Darvon	—1.	—2.	—3.	—4.	(54)
Methadone	—1.	—2.	—3.	—4.	(55)
Other opiates	—1.	—2.	—3.	—4.	(56)

FORM D-1 (Continued)

14. Are there some drugs that you don't use now that you would use if you weren't afraid of getting caught?

(Please check one)

(57)

1. Yes 2. No

15. Are there some drugs that you use less because you are afraid of getting caught using them? (Please check one)

1. Yes 2. No 3. Doesn't apply--don't use drugs

(58)

16. For each of the following please check whether or not it makes you afraid to use some drug, so that you don't use it at all, or use it less? (Check one for each line)

	Makes me <u>afraid</u>	Doesn't make <u>me afraid</u>	
Officers or NCOs in my unit	<u>1.</u>	<u>2.</u>	(59)
Other enlisted men turning me in	<u>1.</u>	<u>2.</u>	(60)
Military Police	<u>1.</u>	<u>2.</u>	(61)
Criminal Investigation Division	<u>1.</u>	<u>2.</u>	(62)
Sniffer dogs	<u>1.</u>	<u>2.</u>	(63)

FORM D-1 (Continued)

17. For each of the following please check whether or not it makes
you afraid to drink more than is good for you?
(Check one for each line)

	<u>Makes me afraid</u>	<u>Doesn't make me afraid</u>	
Officers or NCOs in my unit	— 1.	— 2.	(64)
Other enlisted men turning me in	— 1.	— 2.	(65)
Military Police	— 1.	— 2.	(66)
Criminal Investigation Division (CID)	— 1.	— 2.	(67)

FORM D-1 (Continued)

18. For each substance (item) below, please check whether you use (do) it frequently, seldom, or never on this post. If you don't use (do) it at all (including off the post), mark "don't use (do) at all." (Check only one for each line)

	<u>Use (do) on post</u>			
	<u>Frequently</u>	<u>Seldom</u>	<u>Never</u>	<u>Don't use (do) at all</u>
Drinking too heavily	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4. (68)</u>
Marijuana/hash	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4. (69)</u>
Hallucinogens	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4. (70)</u>
Amphetamines	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4. (71)</u>
Cocaine	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4. (72)</u>
Other uppers	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4. (73)</u>
Barbiturates	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4. (74)</u>
Other downers	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4. (75)</u>
Darvon	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4. (76)</u>
Methadone	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4. (77)</u>
Other opiates	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4. (78)</u>

End of Card 2 2
80

Questionnaire (1) (2) (3) (4)

FORM D-1 (Continued)

19. For each substance (item) below, please check whether you frequently, seldom, or never use (do) it on the job. If you don't use (do) it, mark "don't use (do) at all."

(Check only one for each line)

	<u>Use (do) on the job</u>			<u>Don't use/do at all</u>
	<u>Frequently</u>	<u>Seldom</u>	<u>Never</u>	
Drinking too heavily	1.	2.	3.	4. (5)
Marijuana/hash	1.	2.	3.	4. (6)
Hallucinogens	1.	2.	3.	4. (7)
Amphetamines	1.	2.	3.	4. (8)
Cocaine	1.	2.	3.	4. (9)
Other uppers	1.	2.	3.	4. (10)
Barbiturates	1.	2.	3.	4. (11)
Other downers	1.	2.	3.	4. (12)
Darvon	1.	2.	3.	4. (13)
Methadone	1.	2.	3.	4. (14)
Other opiates	1.	2.	3.	4. (15)

20. Have you ever stopped using all drugs?

(Check one)

- 1. Doesn't apply--never or seldom used drugs (16)
- 2. Yes
- 3. No

FORM D-1 (Continued)

21. Have you ever stopped drinking more than is good for you?

(Check one)

- 1. Doesn't apply--never or seldom drank more than was good for me (17)
- 2. Yes
- 3. No

22. What was the longest period you have stopped taking all drugs?

(Check only one)

- 1. Doesn't apply--I've never or seldom used drugs (18)
- 2. I've never stopped the use of all drugs
- 3. One day or less
- 4. More than 1 days to 2 days
- 5. More than 2 days to 7 days
- 6. More than 7 days to 2 weeks
- 7. More than 2 weeks to 4 weeks
- 8. More than 1 month to 6 months
- 9. More than 6 months to a year
- 0. More than a year

FORM D-1 (Continued)

23. What was the longest period you have stopped drinking more than is good for you? (Check only one)

- 1. Doesn't apply--I've never or seldom drunk more than is good for me (19)
- 2. I've never stopped drinking more than is good for me
- 3. One day or less
- 4. More than 1 days to 2 days
- 5. More than 2 days to 7 days
- 6. More than 7 days to 2 weeks
- 7. More than 2 weeks to 4 weeks
- 8. More than 1 month to 6 months
- 9. More than 6 months to a year
- 0. More than a year

FORM D-1 (Continued)

24. When you stopped using all drugs for the longest period,
what were the important influences on making you stop?
(Check all that apply)

- 1. Doesn't apply--I've never or seldom used drugs/drunk too heavily
 - 2. Doesn't apply--I've never stopped the use of any drugs
 - 3. I was afraid I would get caught by senior NCOs or officers
 - 4. I was afraid I would become strung out or addicted
 - 5. I was afraid I would be no good on the job
 - 6. I had a good experience in treatment or rehabilitation
 - 7. I had reached the legal drinking age
 - 8. My spouse or a friend convinced me to stop
 - 9. What I learned in drug/alcohol education convinced me to stop

(20)

- 0 Drugs were not available
 - 1. Drugs were too expensive
 - 2. I got busted
 - 3. I just made up my mind to stop
 - 4. I tried them, but didn't like them
 - 5. I had a religious experience
 - 6. Other (specify) _____

(21)

FORM D-1 (Continued)

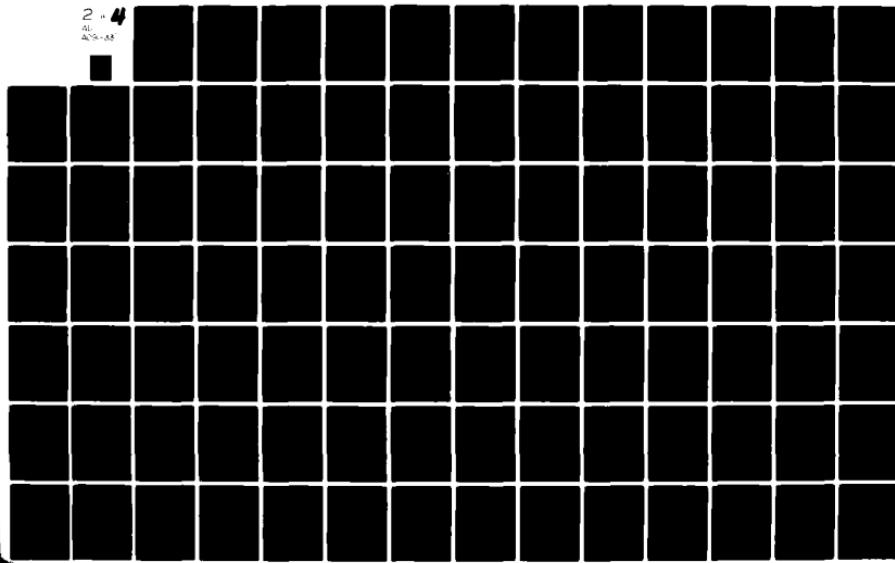
25. When you stopped drinking more than is good for you for the longest period, what were the important influences on making you stop? (Check all that apply)

- 1. Doesn't apply—I've never or seldom drunk more than is good for me (22)
- 2. Doesn't apply—I've never stopped drinking more than is good for me
- 3. I was afraid I would get caught by senior NCO's or officers
- 4. I was afraid I would become an alcoholic
- 5. I was afraid I would be no good on the job
- 6. I had a good experience in treatment or rehabilitation
- 7. My spouse or a friend convinced me to stop
- 8. What I learned in drug/alcohol education convinced me to stop
- 9. I got busted
- 0. I just made up my mind to stop
- 1. I tried it, but didn't like it (23)
- 2. I had a religious experience
- 3. Other (specify) _____

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A HANDBOOK FOR ALCOHOL AND DRUG CONTROL OFFICERS, VOLUME II. AP--ETC(U)
FEB 75 DAHC19-74-C-0019
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FORM D-1 (Continued)

26. To whom would you want to go if you had a drug problem? (*Check as many as apply*)

- 1. Commanding Officer
- 2. Other officer in my unit
- 3. Senior NCO
- 4. Physician
- 5. Chaplain/priest/minister/rabbi
- 6. Friend
- 7. Civilian counselor
- 8. Military counselor
- 9. Girlfriend/wife/boyfriend/husband
- 0. Exemption representative
- X. Drug Education Specialist (DES)
- Y. Drug Abuse Program Advisor

(24)

FORM D-1 (Continued)

27. To whom would you want to go if you had a drinking problem? (*Check as many as apply*)

- 1. Commanding Officer (25)
- 2. Other officer in my unit
- 3. Senior NCO
- 4. Physician
- 5. Chaplain/priest/minister/rabbi
- 6. Friend
- 7. Civilian counselor
- 8. Military counselor
- 9. Girlfriend/wife/boyfriend/husband
- 10. Exemption representative
- X. Drug Education Specialist (DES)
- Y. Drug Abuse Program Advisor

28. To your knowledge, have you ever been identified as a drug user, or not? (*Please check one*)

- 1. Does not apply--never used drugs (26)
- 2. Yes
- 3. No
- 4. Don't know

FORM D-1 (Continued)

29. To your knowledge, have you ever been identified as one who
drinks more than is good for him, or not? (Please check one)

- 1. Does not apply--never drank more than is good for me
- 2. Yes
- 3. No
- 4. Don't know

30. What, if anything, happened to you as a result of being identified?
(Check as many as apply)

- 1. Doesn't apply--never used drugs or drank too heavily (28)
- 2. Doesn't apply--never was identified
- 3. Nothing happened
- 4. Officers/senior NCOs hassled me
- 5. Friends hassled me
- 6. I was transferred to another unit
- 7. It was recommended that I receive treatment
- 8. I was commanded to receive treatment
- 9. I was told about about the exemption program
- 1. It was recommended that I get an exemption (29)
- 2. I was commanded to get an exemption
- 3. I received a disciplinary action
- 4. I was given a reduced paygrade
- 5. I was passed over for promotion
- 6. Other (specify) _____

Now we would like to ask you a few questions about
facilities on this post.

FORM D-1 (Continued)

31. How often, if at all, do you use each of the following facilities?

(Check one for each line)

	<u>Never</u>	<u>Less than once a month</u>	<u>1-3 times a month</u>	<u>Once a week</u>	<u>More than once a week</u>	
Bowling alleys	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	(30)
Riding stables	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	(31)
Tennis courts	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	(32)
Pool rooms	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	(33)
Golf course	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	(34)
Miniature golf course	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	(35)
Auto craft shop	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	(36)
Other crafts shop	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	(37)
Athletic playing fields	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	(38)
Gym	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	(39)
Education center	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	(40)
NCO/EM clubs	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	(41)
Service clubs	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	(42)
Post chapels	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	(43)

FORM D-1 (Continued)

- 32. Would you please rate each of the following facilities as to whether it is excellent, good, fair, or poor? If you have never used the facility, check "have not used." (Check one for each line)**

	<u>Excellent</u>	<u>Good</u>	<u>Fair</u>	<u>Poor</u>	<u>Have not used</u>
Bowling alleys	— 1.	— 2.	— 3.	— 4.	— 5. (44)
Riding stables	— 1.	— 2.	— 3.	— 4.	— 5. (45)
Tennis courts	— 1.	— 2.	— 3.	— 4.	— 5. (46)
Pool rooms	— 1.	— 2.	— 3.	— 4.	— 5. (47)
Golf course	— 1.	— 2.	— 3.	— 4.	— 5. (48)
Miniature golf course	— 1.	— 2.	— 3.	— 4.	— 5. (49)
Auto craft shop	— 1.	— 2.	— 3.	— 4.	— 5. (50)
Other crafts shop	— 1.	— 2.	— 3.	— 4.	— 5. (51)
Athletic playing fields	— 1.	— 2.	— 3.	— 4.	— 5. (52)
Gym	— 1.	— 2.	— 3.	— 4.	— 5. (53)
Education center	— 1.	— 2.	— 3.	— 4.	— 5. (54)
NCO/EM clubs	— 1.	— 2.	— 3.	— 4.	— 5. (55)
Service clubs	— 1.	— 2.	— 3.	— 4.	— 5. (56)
Post chapels	— 1.	— 2.	— 3.	— 4.	— 5. (57)

- 33. Please think a moment about what, if anything, we could do or could do better to help those with drug or drinking problems and write below.**
-
-
-

End of Card 3 $\frac{3}{80}$

Thank you for your help. If you have any other comments, please write them below.

FORM D-2

SAMPLE QUESTIONNAIRE FOR LEADERS:
KEYPUNCH VERSION

DRUG AND ALCOHOL SURVEY

WHAT THIS IS ABOUT

We are trying to find out about the use of drugs and alcohol at this post. You are one of about ____ officers and NCOs filling out this survey.

This questionnaire is for you to fill out anonymously. You cannot be identified, because you are asked not to sign your name. DO NOT SIGN YOUR NAME OR SOCIAL SECURITY NUMBER ANYWHERE ON THE QUESTIONNAIRE.

This survey is not for or against drugs and alcohol. Its only purpose is to get facts, opinions, and attitudes about drugs and alcohol. Unless the question asks otherwise, we are talking about drugs which are used without a prescription.

Your honest answers to this survey will help soldiers who have alcohol or drug problems, now and in the future. Facts learned from this survey will help the post to develop better programs of alcohol and drug education.

Instructions for answering these questions are below. Read them carefully before you begin.

Thanks. We appreciate your help.

FORM D-2 (Continued)

WHAT TO DO

You can answer most of the questions below by making a check mark. Ignore the numbers in italics. They are for computer use only. Make one answer to each question, unless the question says, "Check as many as apply." In a few questions, we ask you to explain or specify an answer or fill in a number. Answer all the questions honestly and carefully. There is no time limit, so take as much time as you need.

Questionnaire No. (1) (2) (3) (4)

FORM D-2 (Continued)

First, we'd like to ask a few questions about you.

1. Are you male or female? (*Please check one*)

1. Male 2. Female (5)

2. How old were you on your last birthday? (*Please check one*)

1. 18 or less 5. 26-30 (6)
 2. 19-20 6. 31-40
 3. 21-22 7. 41-50
 4. 23-25 8. Over 50

3. Which one of the following do you consider yourself?

(*Please check one*)

1. Spanish/Mexican American (7)
 2. White (other than Spanish/Mexican American)
 3. Black
 4. Other (Oriental, American Indian, etc.)

4. What is your marital status? (*Please check one*) (8)

1. Married 4. Widowed
 2. Legally separated 5. Never married (single)
 3. Divorced

FORM D-2 (Continued)

5. What is your highest level of education including accepted GED credits? (Please check one)

- 1. Grammar school (9)
- 2. Some high school
- 3. GED (high school equivalent)
- 4. High school graduate (diploma)
- 5. Post high school trade/technical school (no college)
- 6. 1-3 years college
- 7. 4 years college/degree
- 8. Some graduate work
- 9. graduate degree (masters, doctorate)

6. Where did you live just before going into the Army ?
(Please check one)

- 1. A farm/ranch (10)
- 2. In the country but not a farm/ranch
- 3. Town/small city (less than 25,000 people then)
- 4. Medium city (25,000-100,000 people then)
- 5. Large city (over 100,000 people then)
- 6. Suburb of a large city
- 7. Suburb of a small/medium city

FORM D-2 (Continued)

7. What is your active duty pay grade? (Please check one)

- | | | | |
|---------------------------------|---------------------------------|---|------|
| <input type="checkbox"/> 1. E-6 | <input type="checkbox"/> 5. O-1 | <input type="checkbox"/> 8. O-4 | (11) |
| <input type="checkbox"/> 2. E-7 | <input type="checkbox"/> 6. O-2 | <input type="checkbox"/> 9. O-5 | |
| <input type="checkbox"/> 3. E-8 | <input type="checkbox"/> 7. O-3 | <input type="checkbox"/> 0. O-6 and above | |
| <input type="checkbox"/> 4. E-9 | | | |

8. What is your present Army status? (Please check one)

- | | | |
|--|---------------------------------------|------|
| <input type="checkbox"/> 1. Regular Army | <input type="checkbox"/> 2. Reservist | (12) |
|--|---------------------------------------|------|

9. How many people are in your unit? ("Unit" in this questionnaire means "company.") (Please check one)

- | | | |
|--|--------------------------------------|------|
| <input type="checkbox"/> 1. 50 or less | <input type="checkbox"/> 4. 151-200 | (13) |
| <input type="checkbox"/> 2. 51-100 | <input type="checkbox"/> 5. 201-300 | |
| <input type="checkbox"/> 3. 101-150 | <input type="checkbox"/> 6. over 300 | |

10. What kind of unit do you lead? (Please check one)

- | | |
|---|------|
| <input type="checkbox"/> 1. Combat Arms [for example, Infantry, Airborne, Field Artillery, Armor, Cavalry, Special Forces Engineering Units designated as combat arm units] | (14) |
| <input type="checkbox"/> 2. Combat Support Arms [for example, Signal Corps, Military Police, Aviation, Chemical Corps, Transportation (Direct Support), Ordnance, Engineers not designated as combat arm units] | |
| <input type="checkbox"/> 3. Combat Service Support Arms [for example, Quartermaster, Judge Advocate General, Finance, Medical, Dental, Adjutant General, Military Intelligence, Chaplain, Women's Army Corps, Transportation (General Support)] | |

FORM D-2 (Continued)

11. How long have you been on this post? (Please check one)

- 1. Less than 6 months (15)
- 2. 6-12 months
- 3. Over 1 year to 2 years
- 4. Over 2 years to 3 years
- 5. Over 3 years to 4 years
- 6. Over 4 years

12. How long have you been in the Army? (Please check one)

- 1. Less than 6 months (16)
- 2. 6-12 months
- 3. Over 1 year to 2 years
- 4. Over 2 years to 3 years
- 5. Over 3 years to 4 years
- 6. 5-8 years
- 7. 9-12 years
- 8. 13-20 years
- 9. Over 20 years

13. Do you plan on making the Army your career or not?
(Please check one)

- 1. Yes
- 2. No
- 3. Don't know (17)

FORM D-2 (Continued)

We'd like to get your opinions about the extent of drug use and heavy drinking on this post. First, we will give you a few definitions of terms.

<u>Substance</u>	<u>Examples</u>
Marijuana/hash.....	Pot, grass, hash, etc.
Hallucinogens.....	LSD, mescaline, peyote, STP, DOM, THC, Sernyl, PCP, etc.
Amphetamines.....	Benzedrine, Methedrine, Ritalin, speed, Dexedrine, crystal, etc.
Cocaine.....	C, coke, dust, snow
Other uppers.....	Preludin, any stimulant other than cocaine and amphetamines
Barbiturates.....	Seconal, Nembutal, Amytal, "reds," "yellow," etc.
Other downers.....	Doriden, Mandrax, Quaalude, Sopors, etc.
Darvon.....	Darvon
Methadone.....	Dollies, dolls
Other opiates.....	Heroin, morphine, opium, Demerol, codeine

FORM D-2 (Continued)

1. What percent of your unit do you think are currently using marijuana/hash? (Check one under column A)

What percent are currently using drugs other than marijuana/hash? (Check one under column B)

What percent are currently drinking too heavily?
(Check one under column C)

	<u>A</u> <u>Marijuana/Hash</u> (Check one)	<u>B</u> <u>Other Drugs</u> (Check one)	<u>C</u> <u>Drinking too much</u> (Check one)
None	<u>1.</u> (18)	<u>1.</u> (19)	<u>1.</u> (20)
5% or less	<u>2.</u>	<u>2.</u>	<u>2.</u>
6-10%	<u>3.</u>	<u>3.</u>	<u>3.</u>
11-25%	<u>4.</u>	<u>4.</u>	<u>4.</u>
26-50%	<u>5.</u>	<u>5.</u>	<u>5.</u>
51-75%	<u>6.</u>	<u>6.</u>	<u>6.</u>
Over 75%	<u>7.</u>	<u>7.</u>	<u>7.</u>
Don't know	<u>8.</u>	<u>8.</u>	<u>8.</u>

2. From your experience, about how many people, if any, in your unit are not available for duty on a typical day because they are "strung out" on drugs? (Check one)

<u>1.</u> None	<u>4.</u> Over 10	(21)
<u>2.</u> 1-5	<u>5.</u> Don't know	
<u>3.</u> 6-10		

FORM D-2 (Continued)

3. From your experience, about how many people, if any, in your unit are not available for duty on a typical day because they are under the influence of alcohol? (Check one)

- | | | |
|----------------|----------------------|------|
| <u>1.</u> None | <u>4.</u> Over 10 | (22) |
| <u>2.</u> 1-5 | <u>5.</u> Don't know | |
| <u>3.</u> 6-10 | | |

4. How many, if any, are not available for duty because they have to report for treatment or rehabilitation for drugs? (Check one)

- | | | |
|----------------|----------------------|------|
| <u>1.</u> None | <u>4.</u> Over 10 | (23) |
| <u>2.</u> 1-5 | <u>5.</u> Don't know | |
| <u>3.</u> 6-10 | | |

5. How many, if any, are not available for duty because they have to report for treatment or rehabilitation for alcohol? (Check one)

- | | | |
|----------------|----------------------|------|
| <u>1.</u> None | <u>4.</u> Over 10 | (24) |
| <u>2.</u> 1-5 | <u>5.</u> Don't know | |
| <u>3.</u> 6-10 | | |

6. How many if any, are not working to full capacity because they are under the influence of drugs? (Check one)

- | | | |
|----------------|----------------------|------|
| <u>1.</u> None | <u>4.</u> Over 10 | (25) |
| <u>2.</u> 1-5 | <u>5.</u> Don't know | |
| <u>3.</u> 6-10 | | |

FORM D-2 (Continued)

7. How many, if any, are not working to full capacity because they are under the influence of alcohol? (Check one)

- | | | |
|----------------------------------|--|------|
| <input type="checkbox"/> 1. None | <input type="checkbox"/> 4. Over 10 | (26) |
| <input type="checkbox"/> 2. 1-5 | <input type="checkbox"/> 5. Don't know | |
| <input type="checkbox"/> 3. 6-10 | | |

8. Which of the following drugs can be easily obtained in the community around this post? (Check as many as apply)

- | | | |
|--|---|------|
| <input type="checkbox"/> 1. None | <input type="checkbox"/> 7. Barbiturates | (27) |
| <input type="checkbox"/> 2. Marijuana/hash | <input type="checkbox"/> 8. Other downers | |
| <input type="checkbox"/> 3. Hallucinogens | <input type="checkbox"/> 9. Darvon | |
| <input type="checkbox"/> 4. Amphetamines | <input type="checkbox"/> 0. Methadone | |
| <input type="checkbox"/> 5. Cocaine | <input type="checkbox"/> X. Other opiates | |
| <input type="checkbox"/> 6. Other uppers | <input type="checkbox"/> Y. Don't know | |

9. Which of the following drugs can be easily obtained on this post? (Check as many as apply)

- | | | |
|--|---|------|
| <input type="checkbox"/> 1. None | <input type="checkbox"/> 7. Barbiturates | (28) |
| <input type="checkbox"/> 2. Marijuana/hash | <input type="checkbox"/> 8. Other downers | |
| <input type="checkbox"/> 3. Hallucinogens | <input type="checkbox"/> 9. Darvon | |
| <input type="checkbox"/> 4. Amphetamines | <input type="checkbox"/> 0. Methadone | |
| <input type="checkbox"/> 5. Cocaine | <input type="checkbox"/> X. Other opiates | |
| <input type="checkbox"/> 6. Other uppers | <input type="checkbox"/> Y. Don't know | |

FORM D-2 (Continued)

10. What feelings do you personally have about people in your unit using marijuana/hash? Drugs other than marijuana/hash? Drinking too heavily? (*Check as many as apply for each below*)

	<u>Marijuana/ hash</u>	<u>Other drugs</u>	<u>Drinking too heavily</u>
It's OK	____ 1. (29)	____ 1. (30)	____ 1. (31)
It's illegal	____ 2.	____ 2.	____ 2.
It makes them unfit for duty	____ 3.	____ 3.	____ 3.
It's OK off duty	____ 4.	____ 4.	____ 4.
It ruins their lives	____ 5.	____ 5.	____ 5.
It leads to discipline problems	____ 6.	____ 6.	____ 6.
They should be punished	____ 7.	____ 7.	____ 7.
They need help	____ 8.	____ 8.	____ 8.
They should be discharged	____ 9.	____ 9.	____ 9.
It's a symbol of defiance of authority/discipline	____ 0.	____ 0.	____ 0.
They become deadbeats	____ X.	____ X.	____ X.
They should be transferred	____ Y.	____ Y.	____ Y.

11. Some people think that most soldiers who use drugs had trouble adjusting to the Army (i.e., were troublemakers, incompetents, etc.) even before they used drugs. Do you agree, disagree, or have no opinion? (*Check one*)

____ 1. Agree ____ 2. Disagree ____ 3. No opinion/don't know (32)

FORM D-2 (Continued)

12. Some people think that most soldiers who drink too much had trouble adjusting to the Army (i.e., were troublemakers, incompetents, etc.) even before they began drinking too much.

Do you agree, disagree, or have no opinion? (Check one)

1. Agree 2. Disagree 3. No opinion/don't know (33)

13. Some people think that most soldiers who use drugs had personal problems (that is, were scared, unhappy, unsure of themselves, etc.) even before they used drugs. Do you agree, disagree, or have no opinion? (Check one)

1. Agree 2. Disagree 3. No opinion/don't know (34)

14. Some people think that most soldiers who drink too much had personal problems (that is, were scared, unhappy, unsure of themselves, etc.) even before they drank too much. Do you agree, disagree, or have no opinion? (Check one)

1. Agree 2. Disagree 3. No opinion/don't know (35)

15. Have you known cases in your unit where regulations against drug use were arbitrarily used to take disciplinary action against service members who were drug users for other unrelated kinds of problems such as poor work habits, lack of respect for authority, etc., or not? (Check one)

1. Yes, many 2. Yes, a few 3. No (36)

FORM D-2 (Continued)

16. Some people feel that taking these kinds of actions, based on drug regulations, against problem service members who are also drug users is good for the service; others do not. Regardless of whether or not you think it is done, do you think doing it is good for the service, or not? (Check one)
1. Good for the service 2. Not good for the service 3. No opinion (37)
17. Have you known cases in your unit where regulations against drinking too much were arbitrarily used to take disciplinary action against service members who drank too much for other unrelated kinds of problems such as poor work habits, lack of respect for authority, etc., or not? (Check one)
1. Yes, many 2. Yes, a few 3. No (38)
18. Some people feel that taking these kinds of actions, based on alcohol regulations, against problem service members who also drink too much is good for the service; others do not. Regardless of whether or not you think it is done, do you think doing it is good for the service, or not? (Check one) (39)
1. Good for the service 2. Not good for the service 3. No opinion
19. Would you say that any use of any drug makes a person unfit for any job, or would you say that it depends on things such as dosage, the type of job, the frequency of usage? (Check one)
1. Any use makes unfit 2. Depends 3. No opinion (40)

FORM D-2 (Continued)

20. Would you say that problem drinking always makes a person unfit
for any job, or would you say that it depends on things such
as the type of job and how often this occurs? (Check one)

1. Always makes 2. Depends 3. No opinion (47)

21. The last time that you were told that a soldier in your unit was allegedly using marijuana/hash what did you do? Other drugs? Drinking too much?
(Check as many as apply for each)

	<u>Marijuana/ hash</u>	<u>Other drugs</u>	<u>Drinking too much</u>
Situation has never arisen	____ 1. (42)	____ 1. (44)	____ 1. (46)
Nothing, so long as the person didn't get caught	____ 2.	____ 2.	____ 2.
Counseled the person myself, to get the person to stop	____ 3.	____ 3.	____ 3.
Sent the person for help (to Drug Rehabilitation, Mental Health, etc.)	____ 4.	____ 4.	____ 4.
Accused for purposes of Court Martial	____ 5.	____ 5.	____ 5.
Tried to get the person transferred out of unit	____ 6.	____ 6.	____ 6.
Tried to get the person discharged from the service	____ 7.	____ 7.	____ 7.
Referred the matter to someone higher in the chain of command	____ 8.	____ 8.	____ 8.
Referred the person to the Chaplain	____ 9.	____ 9.	____ 9.
Sent the person to apply for an exemption	____ 1. (43)	____ 1. (45)	____ 1. (47)
Confronted the person with the information	____ 2.	____ 2.	____ 2.
Searched their quarters	____ 3.	____ 3.	____ 3.
Initiated a full investigation	____ 4.	____ 4.	____ 4.
Had someone else tell the person I was watching them and that they should stop	____ 5.	____ 5.	____ 5.
Put the person under administrative restriction	____ 6.	____ 6.	____ 6.
Other (specify)	____ 7.	____ 7.	____ 7.

FORM D-2 (Continued)

22. The last time someone in your unit came to you and reported themselves as a drug user or someone who drinks too much, what did you recommend? (Check as many as apply for each)

	<u>Drug use</u>	<u>Drinking too much</u>
Situation has never arisen	____ 1. (48)	____ 1. (49)
Apply for exemption	____ 2.	____ 2.
Get counseling	____ 3.	____ 3.
Get treatment	____ 4.	____ 4.
Go to hospital	____ 5.	____ 5.
Go see the Chaplain	____ 6.	____ 6.
Stop	____ 7.	____ 7.
OK, but don't get caught	____ 8.	____ 8.
Other (specify) _____	____ 9.	____ 9.

23. What is your relationship with the drug/alcohol program at this post? (Check as many as apply)

- ____ 1. Educational responsibility (50)
- ____ 2. Respond to exemption requests
- ____ 3. Do counseling, formal responsibility
- ____ 4. Do counseling, informal responsibility
- ____ 5. Serve on ADDIC
- ____ 6. Serve on rehabilitation committee/social evaluation committee
- ____ 7. Make re-enlistment recommendations on rehabilitated men
- ____ 8. Initiate drug/alcohol programs in unit
- ____ 9. Other (specify) _____
- ____ 0. No relation with the drug program

FORM D-2 (Continued)

24. About how many of the people in your unit at this post were identified as drug users during the last year? As drinking too much? (*Check one for each*)

	<u>Drug users</u>	<u>Drinking too much</u>
None	____ 1. (51)	____ 1. (52)
1 - 2	____ 2.	____ 2.
3 - 5	____ 3.	____ 3.
6 -10	____ 4.	____ 4.
11-20	____ 5.	____ 5.
21 or more	____ 6.	____ 6.
Don't know	____ 7.	____ 7.

25. How many of these identifications were initially due to your own observations and/or investigations? (*Check one for each*)

	<u>Drug users</u>	<u>Drinking too much</u>
None	____ 1. (53)	____ 1. (54)
1 - 2	____ 2.	____ 2.
3 - 5	____ 3.	____ 3.
6 -10	____ 4.	____ 4.
11-20	____ 5.	____ 5.
21 or more	____ 6.	____ 6.
Don't know	____ 7.	____ 7.

FORM D-2 (Continued)

- 26.** Thinking now about your role in preventing drug use or drinking too much, do you think that it is more important to get drug/alcohol education to the soldier, or that it is more important to identify users/problem drinkers for treatment and rehabilitation, or what? (*Check only one for each column*)

<u>Drug users</u>	<u>Drinking too much</u>
More important to get education to soldier	1. (55) 1. (56)
More important to identify drug users and problem drinkers	2. 2.
Both equally important	3. 3.
Neither is important	4. 4.
Don't know	5. 5.

- 27.** Is it more important to work with soldiers to learn about drug/alcohol problems, is it more important to try to get better support from higher command levels for dealing with drug use and drinking too much, or what? (*Check only one for each column*)

<u>Drug users</u>	<u>Drinking too much</u>
More important to work with soldiers	1. (57) 1. (58)
More important to work with command	2. 2.
Both equally important	3. 3.
Neither is important	4. 4.
Don't know	5. 5.

FORM D-2 (Continued)

28. Please think a moment about what, if anything, we could do or could do better to help those with drug or drinking problems and write it below.

Thank you for your help. If you have any other comments, please write them below.

FORM D-3

SAMPLE SET OF QUESTIONS TO USE IN ANALYZING SURVEY RESULTS

I. How extensive is drug use/problem drinking on the post?

A. By location

- On post/on duty
- On post/off duty
- Off post/off duty
- Off post/on duty

B. By type of drug or by alcohol

C. By background of soldier

- Age
- Marital status
- Ethnic/racial group
- Education
- Military pay grade
- Army status
- Type of unit
- Length of time on post
- Length of service
- Whether or not Army career-oriented
- Whether or not live on post
- Size of town lived just prior to Army

D. By weekend use

E. By group vs. individual use

II. What are prevalent attitudes toward drug use/problem drinking?

A. By type of person

- Soldiers
- Soldiers' perceptions of leaders
- Leaders

FORM D-3 (Continued)

- B. By substance abusers or non-abusers
- C. By background of soldier/leader
 - Age
 - Marital status
 - Ethnic/racial group
 - Education
 - Military pay grade
 - Army status
 - Type of unit
 - Length of time on post
 - Length of service
 - Whether or not Army career-oriented
 - Whether or not live on post
 - Size of town lived just prior to Army
- D. By type of drug
 - Marijuana/hash
 - Other drugs
 - Alcohol
- E. By location
 - On duty/on post
 - Off duty/on post
 - Off duty/off post
- F. By whether or not confirmed

III. What are motivating factors in substance abuse on post?

- A. By background of soldier
 - Age
 - Marital status
 - Ethnic/racial group

FORM D-3 (Continued)

- Education
 - Military pay grade
 - Army status
 - Type of unit
 - Length of time on post
 - Length of service
 - Whether or not Army career-oriented
 - Whether or not live on post
 - Size of town lived just prior to Army
- B. By type of drug/alcohol
- C. By frequency of present use
- D. By change in use on post
- E. By whether or not confirmed

IV. What appear to be constraining/inhibiting factors to substance abuse?

- A. By background of soldier
- Age
 - Marital status
 - Ethnic/racial group
 - Education
 - Military pay grade
 - Army status
 - Type of unit
 - Length of time on post
 - Length of service
 - Whether or not Army career-oriented
 - Whether or not live on post
 - Size of town lived just prior to Army
- B. By type of drug/alcohol
- C. By frequency of present use

FORM D-3 (Continued)

D. By change in use on post

E. By whether or not confirmed

V. What actions are likely to result from being confirmed?

A. By type of person:

- Perception of soldiers

- Perception of leaders

B. By type/frequency of present use

C. By whether or not confirmed

APPENDIX E

HOW TO STATE OBJECTIVES IN TERMS OF RESULTS

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APPENDIX E

HOW TO STATE OBJECTIVES IN TERMS OF RESULTS

1. WHAT IS AN OPERATIONAL OBJECTIVE?

If an objective is to be useful as a guide for program operation and evaluation, it must be stated unambiguously--that is, with no room for misinterpretation. In the case of a results objective it should specify minimum acceptable performance of a specific target group at a specific point in time as a result of the program designed to achieve the objective. In the case of a process objective it should specify a particular set of actions to be taken by the program. Operational objectives enhance the ability of the manager to control the program and to make any mid-course corrections, and they permit comparison of the effectiveness of different techniques to achieve similar objectives. When communicated to the staff of the program, operational objectives enable these individuals to monitor progress throughout and thus improve the chances for a successful outcome.

This appendix is concerned primarily with results objectives: objectives that state what the outcome of the ADAPCP is intended to be. Process objectives--objectives stating how the program is to be carried out--are discussed in Chapter IV of the manual.

A statement of "goals" or "objectives" is a standard feature of most program descriptions. However, these are usually presented in very general terms, and they are not the same as operational guides against which success can be measured. For example, the following statement concerning

Army drug education policy, taken from the report of the "Mack Task Group,"¹ does not provide operational objectives for a drug education program:

"Continuing programs should be provided to augment basic instruction which will result in: (a) attitudinal and behavioral improvement, (b) character and moral development, (c) the assumption of leadership responsibility."

This is a broad statement, open to many interpretations. To put it in operational terms requires determining which attitudes and behaviors should be affected and in what measurable ways, how character and moral development should change, etc., and who the target audience should be. Until the objective is restated operationally, anyone reading it could come up with his own target group, his own ideas of attitudinal, behavioral, and character improvement, and his own criteria for judging leadership responsibilities. As it stands, the statement is not a clear guide to action and cannot be used to measure a program's success or failure.

The following statement, also quoted from the Mack Report comes closer to the operational definition of an objective:

"Basic instructions should be provided concerning the dangers of drug abuse during the initial period of training following entry into the military services."

To operationalize this statement the following question must still be answered: What is the minimum acceptable performance of new recruits as a result of the basic instruction? Since the purpose of the instruction is to bring about change in the recruits, it is not the act of instructing that is important, but the behavior of the recruits as a result of the

1. Vice Admiral P. Mack, USN, Deputy Assistant Secretary of Defense (Manpower and Reserve Affairs) Chairman, Report of the Task Force on the Problem of Drug Abuse in the Armed Forces, 20 August 1970.

instruction. Thus, the statement may be clarified by adding the following:

"...so that X% of recruits will recognize Y [some list of drugs] by appearance, can list side effects of each and can score Z% on a multiple-choice test concerning federal and state laws and Armed Services Regulations concerning drug abuse."

This appendix describes the steps that should be followed in writing meaningful program objectives against which results can be measured. It then presents more examples of operationally stated objectives for drug and alcohol education and rehabilitation programs.

2. STEPS IN WRITING RESULTS OBJECTIVES¹

The Department of Defense and each of the Armed Services have issued statements of policy on drug education and rehabilitation. As pointed out above, some of these policy statements are very broad, whereas others very specifically prescribe what the results of certain types of programs should be. Within the constraints of these policy statements, each ADCO, under the direction of his CO and an ADDIC, has the large task of setting specific program objectives for alcohol and drug education and rehabilitation on his post. Two general points about the approach to objective setting must be highlighted before this discussion turns to a detailed presentation of the approach to writing operational results objectives.

1. The organization of this section of the appendix is based on that used by Robert F. Mager in his Preparing Objectives for Programmed Instruction (San Francisco: Fearon Publishers, 1961).

First, objective setting is an iterative process; that is, it interacts with other processes, in this case the process of information gathering. Objective setting requires that the framer of objectives be familiar with the target group, know the resources--money, staffing, programs and techniques--available for carrying out a program, and understand the overall aims within which the objectives are to be set (total elimination of alcohol and drug abuse, control of the level of abuse so that the Army's functions are not disrupted, control of the type of abuse to minimize harmful effects to the user, etc.). With this information in hand, an initial set of objectives can be developed. Then, as experience is gained with the program--and perhaps with similar programs operated by other institutions--and as the drug or alcohol problem itself is found to change over time, priorities, objectives, and resource requirements are continually reviewed, modified, and it is hoped, made better.

Second, successful use of results objectives requires not only that the managers of a program be aware of the objectives, but also that the participant staff know and understand them. This helps the staff to gauge their own progress and perhaps contribute to the improvement of the process or program content being followed in quest of successful performance.

The first step in setting objectives is to ask what behavior the target group should exhibit at the end of the experience to which it is being subjected. There are four important elements to this question:

- (1) The identity of the target group.
- (2) The desired behavior.

- (3) The conditions under which the behavior is to occur, including the time.
- (4) The criteria for measuring success.

These are discussed briefly below.

a. Specifying the Target Group

Referring to the first quote from the Mack Report discussed in Section 1 above, consider how differently it might be interpreted for different target audiences. For instance, expectations about the type and degree of attitude change would be different for each of these post-target groups: recruits, drug users, problem drinkers, first offenders, non-users, doctors, chaplains, dependent children of service personnel, civilian employees, trainees for positions as instructors, discussion group leaders, or treatment/rehabilitation staff. Thus, before defining any other aspect of the objective, it is important to know who the target group is.

b. Specifying the Behavior Desired (Result)

The second building block of an objective is the desired behavior. This has to be stated in such a way that everyone connected with the program will agree on exactly what is meant. In an education objective such words as "understand," "know," "appreciate" have only very general meanings and can be differently interpreted by different people. If an objective involves having the person "understand" something about drugs or alcohol, either one should think about how he might be asked to show

this understanding in, for example, a test, and state one's objective in terms of words like "choose," "match," "list," "recite," "draw," or "write," or else one should use several statements to pin down exactly what is meant by "understand."

Here are a few examples of objectives relevant to alcohol or drug education programs, with the expected behavior in italics;

- At the end of the drug and alcohol abuse orientation program, recruits will score at least X% on a multiple-choice test regarding the major side effects of substance abuse.
- The number of enlisted men found unfit for duty because of problem drinking will be decreased by X% within the period of n (some number of) months after the start of program A.
- After attending a given session of the post's basic drug and alcohol education program, the number of dependent children of servicemen who, in a questionnaire, indicate indifference to drug experimentation and/or problem drinking will decrease by X%.

c. Specifying the Conditions

The following example illustrates the usefulness of specifying conditions - that is, stating the circumstances under which the desired behavior is to occur:

- (1) The subjects of the rehabilitation program will remain free of drugs for thirty days.
- (2) The subjects of the rehabilitation program will remain free of drugs for 30 days while participating in a live-in program.
- (3) The subjects of the rehabilitation program will remain free of drugs for 30 days subsequent to return to active duty.

If no conditions are specified, as in statement (1), some people could interpret the policy as stated in (2) while others could interpret it as stated in (3). Clearly, the condition of statement (3) is harder to meet than that of statement (2), and it might require a different kind of program. Thus, a statement is not complete if conditions are not specified. The conditions under which the behavior is to occur need to be spelled out at more length as the desired behavior becomes more complex. For example, if the desired behavior is to achieve a score of X% on a particular multiple-choice test, the condition might simply be for example, "one month after completion of the program," while if the desired

behavior is to discuss the side effects of drug knowledgeably, conditions would have to be specified concerning the setting for the discussion, its length, whether notes can be used, etc. (Also, the minimum acceptable performance--what is "knowledgeable" discussion?--would have to be carefully defined.) Minimum acceptable performance is discussed below.

d. Specifying Evaluation Criteria

Evaluation criteria are usually expressed in terms of the minimum performance level that is considered to meet the objective. The following examples specify minimum acceptable performance:

- At the end of the n-month group therapy program, at least X% of the participants will change their attitudes from willingness to experiment with drugs to unwillingness.
- At least Y% of the men treated for problem drinking will not relapse for n period of time after reinstatement to active duty.

In the second instance, a condition for the desired behavior ("for n period of time") is also part of the minimum acceptable performance.

Up to this point all examples have used quantitative evaluation criteria abbreviated by such notations as X%, n, Y, X, etc. In some cases, more qualitative expressions of the evaluation criteria may be needed. For example, the desired behavior may be confidence displayed in expressing opinions, and the condition may be the presence of peer group members, some of whom may hold an opposing point of view. It may

not seem possible to make this objective specific concerning minimum acceptable performance. However, it is still possible to spell out the attributes of the desired behavior--in this case, to describe what is meant by "confidence." For example:

Before attendance in group therapy sessions is no longer required, the target person (or persons) should have expressed his opinion with increasing regularity in groups where he knows one or more persons and in groups where he is unfamiliar with everyone including the group leader. The decision about release from the therapy sessions should be a team decision among at least three group leaders, with reviews taking place at two-week intervals.

e. Conclusion

In summary, the basic requirements for stating objectives are clarity and completeness. If the intended meaning is fully communicated to everyone involved in or evaluating the program, the objective is usable. Of course, this does not guarantee that it is an appropriate objective, but at least there will be a minimum of guesswork involved in determining its appropriateness.

The words "specify" and "specificity" have appeared in this discussion almost as frequently as the word "objective." Specificity means being very clear and exact about what one is saying. However, it does not mean rigidity. Objectives are simply measurable ways to describe what is to be achieved and see whether it, in fact, has been achieved. They should be changed when program goals change or when improved means

of measuring results are found. As the situation changes, or as better information about it is obtained, new objectives will need to be formulated and stated with the same specificity as the old.

3. MORE EXAMPLES OF OPERATIONALLY STATED OBJECTIVES

a. For Army Alcohol and Drug Education

The major results sought through Army alcohol and drug education programs are increased knowledge or information about substance abuse changed attitudes toward drugs and alcohol, and changed actions (use patterns, self-referrals, etc.) concerning substance abuse. Thus, there are three different types of objectives for drug/alcohol education programs.

(1) Knowledge and Information. Objectives involving increased knowledge of information can often be stated in terms of the ability to recite or recall facts concerning drugs, alcohol, substance abuse and related laws, though sometimes they may require more complex behavior such as analysis or evaluation based on the learning experience.

One stated goal of Army education is as follows:

"To transmit accurate information about alcohol and other drugs to increase understanding of the social and psychological factors in the abuse of alcohol and other drugs."

To be converted to operational objectives, this goal would have to be broken down into several parts and the target, behavior, conditions,

and minimum performance specified for each part. The following are three of the many possible objectives that could be derived from the goal:

- At the end of the drug orientation program, X% of the recruits should be able to recognize the n most common drugs by sight and to associate the n most common side effects with each.
- Attendees of the program should be able to list n or the most important legal consequences (a list should be included) of drug trafficking.
- Chaplains, doctors, COs, and NCOs should know what services programs are available to drug users and problem drinkers in order to direct any service personnel or DOD employee to the proper drug referral agency or agent. They should be able to demonstrate their familiarity to the satisfaction of the ADCO in a discussion period at the end of the orientation meeting.

(2) Attitudes. Attitudes are part of a group of behaviors involving emotions, known as "affective behavior." Going from simple to more complex, some examples of affective behavior are interest, attitudes, values, appreciation, and adjustment. The surveys presented and discussed in Appendix D include items to inventory or measure affective behavior. If measures are taken in the same group at several different times, changes in attitude can be identified.

Frequently, drug/alcohol education programs seek to influence attitudes by providing information. This change is most commonly expected as a result of "cognitive dissonance," the situation encountered when information acquired as part of one experience conflicts with beliefs (perhaps expressed in attitudes or a value system or philosophy of life) based on other experiences. For example, as a result of peer group experience a recruit may have experimented with certain drugs reputed to be "safe." However, as a result of the drug education program he may learn that there is scientific proof that these drugs can have serious physical side effects. If he sees no reason to disbelieve the education program and yet has never experienced these side effects or known anyone who has, he does not know what to think. On a test of his knowledge about these drugs he may be able to describe the side effects accurately. However, if he does not really feel as though the drugs are dangerous his attitude will not change. On a test measuring only attitudes, his responses would make the education program appear to have failed, even though it had imparted information successfully. This illustrates the importance of having a separate objective, with its own performance measures, for each result one is trying to achieve--in this case, increased knowledge and changed attitudes.

It is possible to derive many attitudinal objectives from the same quote used above for informational objectives. Two examples are:

- At least X% of those who indicated a neutral attitude toward drug experimentation on a survey made before exposure to the program should indicate an unwillingness to experiment with drugs on a survey at the end of the program.

- Of those people in the target group who earlier said they did not think alcohol could produce social and psychological side effects similar to those of illegal drugs, X% will have changed their minds at the conclusion of the program segment on alcohol and its social and psychological side effects.

(3) Actions Concerning Alcohol and Drugs. Often, the ultimate objective of an education program is to influence people's actions--by bringing about a desired behavior, eliminating an objectionable behavior, or causing the incidence of a given behavior to increase or decrease. Alcohol and drug education objectives are most often aimed at reducing the incidence of problem drinking and drug use and increasing voluntary participation in treatment. For example:

- The percentage of problem drinkers who volunteer for treatment should be increased by X% after exposure to the program.
- The incidence of first-time offenders for smoking marijuana should be cut by X% after exposure to the program.
- The number of servicemen reporting to duty while drunk should be decreased by X% after exposure to the program.

b. For Army Alcohol and Drug Rehabilitation

One published statement of the Army alcohol and drug treatment and rehabilitation states that it is:

"To attempt to restore to effective and reliable functioning all individuals with problems attributable to alcohol and other drugs"

and to eliminate from the service those who cannot be effectively "restored in a reasonable time."

It is possible to translate the above two quotes into operational objectives. Some examples are:

- After release from the live-in center alcohol treatment program, the former client should remain free from problem drinking for at least n period of time.
- At least X% of (a given type of) drug users in local live-in treatment centers can be returned to duty within n days (or weeks). The criteria for fitness for duty are: _____, _____,... (e.g., lack of dependency on drugs, positive attitude toward work and the Army as evidenced by own statements).
- No more than X% of those in local drug rehabilitation programs should have to be referred to a VA treatment or rehabilitation program as a prelude to discharge. The conditions of referral are: _____, _____,... (e.g., time, number of relapses, cooperation--defined specifically).

- No more than X% of the career servicemen who have been through the drug rehabilitation program for addictive drugs should return to drug dependency of the same or different type--including alcohol--for a period of an n-year followup.

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APPENDIX F

ATTITUDINAL CHANGE

APPENDIX F
ATTITUDINAL CHANGE

Gordon Allport (1937)¹ defined attitude as having five aspects:

- (1) It is a mental and neural state
- (2) Of readiness to respond
- (3) Organized
- (4) Through experience
- (5) Exerting a directive and/or dynamic influence on behavior.

There are three components of attitudes. One is the cognitive, how a person perceives an attitude object; the second is affective, how a person feels about the object of an attitude; the third is conative, how a person behaves toward an attitude object.

Before one attempts to change attitudes, it is important to recognize that they fill several different functions in our lives. The procedures for changing an attitude will be closely dependent upon the function it plays. These functions are:

- (1) Utilitarian or adaptive. A person adopts an attitude which will help him maintain a satisfactory relationship with some other person (peer group, authority figure, etc.). Attitudes which are based on these types of role relationships can be changed by altering the person's role relationship to those other people who are significant, or by changing his perception of where they stand on a particular issue.

¹ Gordon W. Allport, Personality: A Psychological Interpretation
(New York: Henry Holt, 1937).

(2) Economy or knowledge. We need attitudes to give us simplified and practical guidelines of appropriate behavior towards specific objects; this gives us an easy way of organizing some of the complexities of life. It is sometimes possible to change attitudes of this type with new information or new experiences, but this is always very difficult. Since these attitudes are useful, they have a high threshold for change, and a great deal of new knowledge and several new experiences may be necessary in order for a person to be willing to discard these and substitute others, with the resultant upheaval and change required in the rest of the "practical guidelines of appropriate behavior."

(3) Expressive or self-realizing. Oftentimes our attitudes provide emotional outlets or opportunities for self-assertion. It is possible to change an attitude whose function is "expression" by providing a person with another mode of expressing himself or with other issues on which he can be expressive. In those cases where expressive attitudes are also used for self-assertion, this is more difficult. Usually the person has adopted an attitude to bolster or justify his behavior, and once these two are intertwined, it is difficult to disengage them.

(4) Ego-defensive. Attitudes which derive from a person's inner needs may have only the most accidental relationship to the object of the attitude. An insecure person, for example, might become a drug user because he feels important, even more powerful than his officers, while he is in his euphoric, drugged state. It is very difficult to change this person's attitude toward drug use when it provides this ego release for him.

When attempting to change attitudes, it is important to remember that there is a real difference between attitudes and values. Attitudes can, to some extent, be changed by a variety of techniques. But, at a certain point, one's attitudes are chained to fundamental, firmly entrenched values--for example, belief in the "right of life" and hence rejection of abortion, or certain religious beliefs which prohibit the use of drugs and alcohol--and these values need to be uprooted and replaced before any further changes in attitude and behavior can take place.

APPENDIX G

PROGRAM MONITORING: EDUCATION

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APPENDIX G

PROGRAM MONITORING: EDUCATION

Chapter V of the handbook has described the reasons for program monitoring. This appendix focuses on the instruments needed to monitor the education component of the ADAPCP. It suggests (1) how to monitor the size and composition of the audience for alcohol and drug education, the messages presented, the media used, and the characteristics of the instructors, and (2) how to maintain an inventory of resources available to the program--both resources within the ADCO's control and those outside it. Several sample forms are included. All of the material presented can be modified as appropriate to the individual post.

1. AUDIENCE, MEDIA, AND MESSAGES

a. Who Should Collect the Data?

Responsibility for data collection will depend on how the education program is set up. If it is centralized--that is, if it is conducted by the ADAPCP either at a central location or in each unit--the ADAPCP instructors and staff would normally have primary responsibility for collecting the data. If it is decentralized--that is, conducted by the unit commander, DES, or others--data collection is likely to be a responsibility of the unit administrative staff or instructors.

The advantage of collection by the ADAPCP is that it provides more control over the data generation, collection, and storage process. It also makes evaluation and program modification easier, since the data have been under the control of the program. On the other hand, collection by the ADAPCP staff diminishes unit-level involvement in the program and also adds to the burden of paperwork in the ADAPCP office.

Collection at the unit level has the advantage of forcing the unit command to be--at least periodically--more aware of the education program and to pay more attention to exposing the men to the program. This is particularly true if the ADCO can require that the data be forwarded to the ADAPCP office after unit level collection. There are several obvious disadvantages, the most important being the problem of quality control in the data generation, collection, and storage. Unit commanders and their administrative staff have other priorities; and alcohol and drug education may not rank near the top of their list, while it does rank near the top of the ADCO's list.

If the education program is decentralized and conducted primarily at the unit level, special care will be needed to ensure the reliability of the data collection process. The individual in each unit who will be responsible for data collection should be specified and then held accountable. Conclusions derived from unit-by-unit data are only as valid as the quality control procedures at the unit level. To verify the validity of the data collected, ADAPCP staff might do well to monitor unit programs on a sampling basis. This can be particularly useful in the case of information that calls for personal observation and judgment rather than simply numbers.

b. What Data Should Be Collected?

Form G-1 at the end of this appendix is a sample instrument for recording data on audience, media, and message. Its purpose is to monitor alcohol and drug education activities against the stated process objectives of these activities. For example, the program may have set a process objective that X number of personnel are to receive instruction in a particular time period using specified media and containing specified messages. Periodic review of summaries from the Form G-1 data enable staff to check that this objective is being met.

The data can be collected by the instructor during each session, usually in a very short period of time. The student data can be collected by questioning (e.g., show of hands) and the media/message data can be filled out by the instructor during or after the class. It is in the monitoring of media and messages that the need for reliable personal observation noted above becomes most important.

One aspect of drug education messages that needs to be monitored is their accuracy. All factual information provided should be accurate, and it must therefore be of recent vintage. In order to ensure this, the ADCO will need to rely on specialized sources. Potential reviewers include local medical staff, ADAPCP personnel, and clients in drug treatment/rehabilitation programs.

If any factual items concerning pharmacological or medical aspects are to be imparted by DES's, outside lecturers, etc., it is important that accuracy be maintained even on non-essential aspects. Any errors will be eagerly pounced upon by the drug-sophisticated members of the

audience and pointed out to the naive, either in class or subsequently. The resultant loss of credibility could sabotage the entire effort, even if the apparent errors are not such as to affect a rational decision concerning whether or not to use drugs. Since many drug users are very thoroughly informed about the facts, any speaker who presents factual material must be knowledgeable. If no sufficiently qualified speakers are available, it is probably better to avoid factual subject matter. This applies to films and other media as well as lectures. If a film includes factual data, it should (unless it is very recent) be carefully edited.

c. How Often Should the Program Be Monitored?

A decision should be made on how frequently alcohol and drug education is to be monitored. The data should be collected with each class, but summaries will need to be prepared and reviewed at regular intervals, perhaps weekly or monthly. How often will depend upon what program staff will do with the data. Will they simply be stored in the files and summarized annually? Has the CO requested frequent updating on the progress of the ADAPCP? Have changes in program strategies been made, necessitating frequent information on how rapidly the changes are being implemented?

2. INSTRUCTORS

It is useful to maintain basic information on the education program instructors. Form G-2 is a form for this. It can be self-administered by the instructor and kept on file at the ADAPCP office.

3. RESOURCES DEVOTED TO DRUG AND ALCOHOL EDUCATION

The handbook outlines the importance of monitoring human and physical resources devoted to alcohol and drug education, both those under the ADCO's control and those not under his control. Forms G-1 and G-2 would provide some of the necessary information on human resources. However the focus here is not on checking to see that the program is being carried out, but rather on having an accurate inventory of available resources.

The first step the ADCO should take in monitoring resources is to define carefully and completely which resources really are under ADCO control and which are not. For example, if MEDDAC staff conduct education programs on behalf of the ADAPCP, can program staff direct what lesson plans they prepare and how much time they spend, or are they simply "on loan," with their own program design?

a. Resources Under the Control of the ADCO

Assuming that the ADCO knows what resources are under his jurisdiction, what data need to be monitored? First, he should periodically monitor his staff (counselors, instructors, rehabilitation workers, etc.)--their numbers, qualifications, training, time spent on education related activities (e.g., hours spent on lesson plan preparation, platform time, etc.)

Form G-3 is an instrument for obtaining these data. The information need not be collected very often, but it should be kept up to date as changes in the staff occur. Second, there are physical resources under the ADCO's control which are used for alcohol and drug education. Form G-4 is a form

for monitoring physical resources which can be modified to meet program requirements. This information is essentially an inventory and should be updated every 90 or 180 days.

b. Resources Not Under ADCO Control

Resources which are outside the ADCO's control are more difficult to monitor. The quality and quantity of the data available may be in direct proportion to the relationship (formal, informal, personal) program staff have developed with the leadership structure controlling those resources. Such personal and organizational factors as CO support, friendship with other commanders, level of drug usage, and attitude of law enforcement officials will often have major impact on the staff's ability to gather data. The ADCO should make an objective assessment of the state of these relationships when determining how to approach this aspect of the monitoring process.

A first step might be to make a comprehensive listing of the resources outside the ADAPCP that are contributing to alcohol and drug education. These are primarily human resources. Typically, they include (but are not limited to) the following:

- Adjutant General
- MEDDAC
- Provost Marshal
- Judge Advocate
- Unit commanders
- DES's
- Off-post community agencies
- Chaplain

It will probably not be possible to monitor these resources frequently.

The time of program staff is limited, and the resources or those in charge of them will have higher priorities than filling out monitoring instruments for the ADAPCP. Perhaps in no other monitoring activity does so much depend upon the ADCO's ingenuity.

The following information should be sought, through formal or informal channels, concerning resources not under the ADCO's control:

- Name
- Rank
- Job position
- Role in relation to alcohol and drug education
- Qualifications
- Training
- Experience
- Approximate percent of time devoted to alcohol and drug education

In some cases, it may be possible to use a modified version of Form G-3 for obtaining this information.

FORM G-1

SAMPLE FORM FOR MONITORING
ALCOHOL AND DRUG EDUCATION: AUDIENCE, MEDIA AND MESSAGES

Location _____

Unit _____

Instructor
(Name and Rank) _____

Date _____

Length of Session _____

Audience

Size of Class _____ (total number)

Pay Grade:

E-1 to E-3 _____ (total number)

E-4 to E-6 _____

E-7 to E-9 _____

O-1 _____

O-2 _____

O-3 _____

O-4 and over _____

Media: Indicate P (Primary--most time spent) or S (Secondary--less time spent)

_____ Lecture

_____ Discussion

_____ Films/slides

_____ Skit/play

_____ Rap session

Was the atmosphere _____ formal _____ informal?

FORM G-1 (Continued)

Message(s): Indicate P (Primary--most time spent) or S (Secondary--less time spent)

1. Facts, pharmacology, sociology
2. Consequences of alcohol or drug use
3. Understanding of self
4. Alternatives to alcohol or drug use
5. Policy
6. Dangers of alcohol or drug use
7. Make up your own mind
8. Where to get help to get off drugs or alcohol
9. How to handle drug-related emergencies
10. How to avoid hepatitis
11. Service regulations about drug use
12. Other (specify) _____

Accuracy of factual information presented:

Some inaccuracies (specify) _____

No inaccuracies _____

FORM G-2

SAMPLE FORM FOR MONITORING
ALCOHOL AND DRUG EDUCATION: INSTRUCTORS

Instructor Name and Rank _____

Reports to: ADCO

Unit, specify _____

MEDDAC

Judge Advocate's Office _____

Provost Marshal

Other, specify _____

Type of Instructor/Job Position

What type:

- | | |
|--|---|
| <u>Alcohol and Drug Education Specialist</u> | <u>Other officer from unit</u> |
| <u>Drug Education Specialist</u> | <u>Former drug user</u> |
| <u>Educator from ADAPCP</u> | <u>Psychologist</u> |
| <u>Other full-time member of ADAPCP (including rehabilitation) (specify)</u> _____ | <u>Social worker</u> |
| <u>Chaplain</u> | <u>Provost Marshal/CID/MP</u> |
| <u>NCO from company</u> | <u>Psychiatrist/other kind of physician</u> |
| <u>Company Commander</u> | <u>Former problem drinker</u> |

Other _____
(specify)

FORM G-2 (Continued)

Has instructor received formal training in methods of drug education

Yes _____ No _____

List names of courses taken

_____ Total hours of teaching (platform) time

_____ Months with drug education program

_____ Months at this post

FORM G-3

SAMPLE FORM FOR MONITORING
ALCOHOL AND DRUG EDUCATION: HUMAN RESOURCES UNDER ADCO CONTROL

Name:

Date:

Rank:

Post:

Job Position:

Job Description:

QUALIFICATIONS

Personal Involvement in Alcohol and Drug Education

How long have you been in the alcohol and drug program at this
installation? _____ (months)

How long have you been in your present job in the program? _____ (months)

Training and Experience

Relevant civilian job experience you may have had prior to entering the service.

Civilian Experience

Number of Years

FORM G-3 (Continued)

Other alcohol and drug education related experience in the service prior to your present job?

<u>Position</u>	<u>Length of Time on Job</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Training relevant to alcohol and drug education prior to entering service (including college majors and courses, other seminars and workshops, etc.)

<u>Type of training (types of degrees received; subject matter or title of courses, seminar, or workshop)</u>	<u>IF COURSES, estimated credit hours received</u>	<u>IF NOT, length of training in weeks</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other training (courses, seminars, panels, workshops, etc.) for drug education while you were in the service?

<u>Subject matter and type of training</u>	<u>Location</u>	<u>Duration (weeks)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FORM G-3 (Continued)

TIME ALLOCATION TO EDUCATION PROGRAM (hours/week)

Curriculum development _____

Lesson Plan Preparation _____

Platform time _____

Testing/evaluation _____

Follow-up _____

TIME ALLOCATION NOT RELATED TO EDUCATION PROGRAM (hours/week)

Administrative duties _____

Other _____

FORM G-4

SAMPLE FORM FOR MONITORING
ALCOHOL AND DRUG EDUCATION: PHYSICAL RESOURCES UNDER ADCO CONTROL

Media Equipment (Number and Description)

Film Projectors _____

Viewgraph/Overhead Projectors _____

Slide Projectors _____

Other _____

Educational Materials (number and Description)

Periodicals _____

Books _____

Magazines _____

Programmed Instruction _____

Film _____

Slide _____

Videotape _____

Other _____

Facilities

Buildings _____ (number of rooms)

Classrooms _____ (student capacity)

Other _____

APPENDIX H

PROGRAM MONITORING: REHABILITATION

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APPENDIX H

PROGRAM MONITORING: REHABILITATION

Basically, the following information is needed for effective monitoring of the rehabilitation program:

(1) Entry interview data, including:

- Drugs used prior to entry
- Means of identification

(2) Progress reports, which explicitly show:

- Services offered
- Number of clients, length of time in rehabilitation, follow-up

(3) Data on treatment being provided by civilian agencies

(4) Record of resources devoted to rehabilitation

The military reports that each installation is required to submit should be a useful tool. However, in many instances the existing reporting structures are decentralized and fragmented, and it may be that much of the information being collected now bypasses the ADCO's office. This appendix discusses how to make the most effective use of existing information in the above categories and also how to collect any additional information needed to monitor the rehabilitation program. As indicated, it is suggested that the treatment and rehabilitation (T/R) staff be made responsible for information gathering, with the officer in charge of T/R responsible for preparing the periodic summaries needed.

1. ENTRY INTERVIEWS

a. Interview Contents

One of the most sensitive areas to deal with is the initial contact between a client and a member of the T/R staff. Regardless of how the client arrived at T/R he is sure to have undergone a number of "intake" interviews and will undoubtedly be a bit reluctant to answer more questions. Nevertheless, there is certain information that the T/R staff should obtain in this initial interview. DA Form 2985-2R, which calls for similar background information, can be completed by a T/R staff member at the same time as the entry interview. Form H-1 at the end of this appendix is a suggested format for obtaining some important basic information in a concise manner during an initial conversation between client and counselor.

In Form H-1, the suggested contents of Question 4 on means of identification are repeated directly from DA Form 2985-1R, Section 32, and the suggested contents of Question 6 from DA Form 2985, Section 20. Inclusion of these items on the simplified entry interview keeps the manner of reporting consistent with military terminology and reporting mechanisms. It might be a good idea to have the simplified entry forms and other reporting forms printed on two different colors of paper, one used for drugs and one for alcohol. This will identify clients to the staff more easily and will facilitate reporting.

b. Summaries

The next step in monitoring entry data is to decide what information from this form should be summarized periodically and who will prepare the

summaries. Since this entry interview is being conducted in the T/R facility, the form is filed there. It would seem appropriate that the officer in charge of T/R abstract the information indicated below from the entry interviews and submit it to the ADCO on a monthly basis. It is advisable to include the number of clients for both drugs and alcohol for the reporting month and the three previous months. This provides a good picture of trends in each unit for at least four months at a time.

(1) Alcohol and Drug Entrants by Unit.

All that is necessary here is to go through the entry interviews each month and list the number of alcohol clients and drug clients from each unit this month and for the three previous months, thus:

Month of _____

Unit	No. Entered for Drugs				No. Entered for Alcohol			
	Nov.	Oct.	Sept.	Aug.	Nov.	Oct.	Sept.	Aug.

This information will show whether there is any pattern to referrals of drug users or problem drinkers in certain units. It also may provide an indication of changing patterns of substance abuse, which can then be checked out through personal contacts with unit commanders and leaders in these units. A change in clients does not necessarily mean that abuse patterns are changing. It could instead be caused by more resolute leadership in the unit.

(2) Means of Identification.

This is another item that should be summarized and submitted to the ADCO on a monthly basis. Again, the OIC of T/R can go through all the alcohol and drug interviews for the past month and abstract the data. To make this as easy as possible, the entry interview form (Form H-1) could be used and the gross numbers inserted in the blank spaces. For example, if three people in the past month entered the drug program via self referral, the form could be filled in thus:

<u>Biochemical Testing</u>	<u>Other Methods</u>
a. Initial entry on active duty	h. Self-referral <u>3</u>
b. Reentry with prior service	i. Medical _____
c. First reenlistment	j. Investigation-apprehension _____
d. DEROS from RVN, Thailand	k. Command referral _____
e. Command directed	l. Other (specify) _____
f. Random unit testing	_____
g. Rehabilitation staff	_____

A separate form should be used for alcohol. If two problem drinkers entered via medical intervention and one via self referral, the form can be filled in thus:

<u>Biochemical Testing</u>	<u>Other Methods</u>
a. Initial entry on active duty _____	h. Self-referral <u>/</u>
b. Reentry with prior service _____	i. Medical <u>2</u>
c. First reenlistment _____	j. Investigation-apprehension _____
d. DEROS from RVN, Thailand _____	k. Command referral _____
e. Command directed _____	l. Other (specify) _____
f. Random unit testing _____	_____
g. Rehabilitation staff _____	_____

To maintain continuity, it is advisable to obtain this second summary regularly even if no one entered the program during the month. If this happens, 0's can be entered in each space. Some of the answers to the questions in this table could serve as indicators of the effectiveness of other components of the ADAPCP. If large numbers of soldiers are entering the T/R program voluntarily, for example, this may indicate that the education program is effectively reaching those who need T/R. However, caution is always important in drawing conclusions. In this case, maybe they are volunteering because the supply of their drugs has dried up, or they are afraid of being caught by new detection techniques, or they want to avoid overseas service. The form calls attention to the fact that something has changed, and it is then possible to investigate what has caused the change. In this example, that information might be obtained by interviewing some of the voluntary entrants.

2. PROGRESS REPORTS

Periodic progress reports to the ADCO from his staff are also important for effective monitoring of the program. As a general rule, monthly reporting mechanisms are desirable. Progress reports should include the following information:

- (1) Services offered
- (2) Number of clients
- (3) Length of time in rehabilitation
- (4) Follow-up

a. Services Offered

In order to monitor the services being offered, it is necessary to know how these services are staffed. This information should be gathered for both the treatment facility and the detoxification unit of the hospital, since both are elements of the program. A simple reporting form such as Form H-2 can be used. To illustrate the use of this form, it has been filled in for a hypothetical program. The program has one military general-duty MD, Grade O-4, who spends 20% of his time in the drug program; one civilian MSW social worker, Grade GS-11, who spends 50% of his time in the drug program and 50% in the alcohol program; and two military counselors, Grade E-5 and E-6, one of whom spends 100% in the drug program and one who spends 100% in the alcohol program.

The OIC of T/R can be responsible for preparing this form once a month. He can be responsible for providing the OIC of the detoxification unit a supply of these forms and for collecting the completed form from him each month so the two can be submitted at the same time.

Also to be monitored is the extent to which these people are rendering the services intended. Form H-3 is a suggested format for collecting this information. It is a simplified encounter form designed to show the level of activity of treatment modalities and also the number of clients that did or did not appear for a given session. Each time that a session is scheduled, the T/R staff member in charge should fill out a form for each person in the group.

Another component of the rehabilitation program which should be monitored is the level of participation of dependents. For the most part, the information monitored for dependents can be the same as for clients, and it may be possible to use the same encounter form so long as it is clearly identified (possibly another color) as containing information on a dependent rather than a client.

Once the data have been collected, they can be summarized and submitted to the ADCO on a monthly basis. This responsibility again can rest with the OIC of T/R. Once he has all the raw data from each individual encounter form, the summary might look like Form H-4.

The summary can be useful in a number of ways. For example, it shows, in gross numbers, the level of activity of the program. It can also point out problem areas. If there are numerous absences, the raw data are still available and can be reviewed in search of the cause--for example, a problem within the unit or a problem with a member of the T/R staff.

Data about dependents may also be summarized, using a format such as Form H-5.

b. Number of Clients, Length of Time in Rehabilitation, Follow-up

It is important to know how many people are being served in the T/R program at all times. It is equally important to know how long each person in rehabilitation spent there and what happened to each person after completing rehabilitation.

DA Form 2985-3R is the regulation patient data system and follow-up record. This contains good information, but its constraint is that it is not current; it must be prepared beginning after 60 days of rehabilitation

and each 60 days thereafter up to 360 days. Some of Form 2985-3R is incorporated into the procedures suggested here, but the form is not used in its entirety.

It is suggested that the information shown in Form H-6 be obtained monthly on the status of each client in the program. In addition to preparing a form on each patient in the rehabilitation facility, the OIC of T/R can be responsible for supplying the hospital detoxification unit with forms and for collecting them from the hospital for tabulation. Again, one should be done for alcohol and one for drugs in each facility. In order to complete this form the OIC of T/R can obtain information from other T/R staff (counselor, social worker, etc.) and also from the client's commanding officer.

It is also important for program staff to know something about those no longer in the program and the procedures for follow-up. Again, the OIC of T/R can collect the data monthly for each client, for both drugs and alcohol and from both the detoxification unit of the hospital and the T/R facility. Form H-7 is a sample form.

The data can then be summarized in whatever manner is most useful. For Question 1 on Form H-6, perhaps a summary form such as Form H-8 would be appropriate. A line of Form H-8 is filled in to show that 8 clients were left in the halfway house at the end of the previous month, 1 was admitted to the halfway house during the month and 2 were discharged from the halfway house during the month. A rule of thumb to remember in summarizing the data is that the sum of Columns 1 and 2 minus Column 3 always equal Column 4, and Column 4 becomes Column 1 for the next month.

This provides information on the status of the program, which can be further broken out to show the status of the individuals in Column 3 ("Total No. Discharged During Reporting Month"). The raw data can come from the answers to Question 5 on Form H-7. The summary form, prepared separately for drugs and for alcohol, could look like Form H-9. The total for all columns in Form H-9 should equal the total for Column 3 in Form H-8.

It is also useful to know, in summary form, by month, something about military effectiveness, adjustment difficulties, urine test results, and an estimate of drug/alcohol use while in rehabilitation (Items 2-5 in Form H-6). Form H-10, completed by the OIC of T/R once a month, should adequately summarize this information. Again, separate forms are needed for drugs and alcohol.

The last summary needed on a monthly basis is some summary of the civilian follow-up services arranged after a client has left the Army. The OIC of T/R might complete a summary form such as Form H-11, one for drugs and one for alcohol. The raw data will come from Items 6 and 7 of the individual follow-up form, H-7.

3. NUMBERS TREATED BY CIVILIAN AGENCIES

Another very important part of the monitoring activity should be to get some idea of how many people on the post, other than those referred by the program after separation, are being treated in outside civilian facilities, and what type of help they are obtaining. This is difficult because civilian agencies maintain the confidentiality of people who seek assistance. No attempt should be made to identify these people by

name, but it should be possible to learn the numbers of people seeking help for drug-related or alcohol-related problems and where they are seeking this help. Civilian agencies cannot be required to submit reports, but usually they will be glad to provide information on how many post personnel they are treating and for what, since most of these agencies obtain funding on the basis of the number of people they treat. The ADCO's office could maintain a list of such civilian facilities and attempt to establish an informal, but regular, relationship.

4. INVENTORY OF RESOURCES DEVOTED TO REHABILITATION

In order to be able to assess the effort devoted to the T/R program, the ADCO should know what resources have been allocated to the program in terms of dollars and personnel, and of those personnel allocated, how many positions are filled. The information needed about personnel, on an annual basis, is shown on Form H-12. This form can be matched against Form H-2, which shows actual positions filled.

It is important to know the actual expenditures of the program for the past fiscal year, as a guide in establishing a projected budget for the coming year. The professional and paraprofessional staff budget will usually be standard and set for the program, and the ADCO will need a copy of it. However, decisions need to be made on the allocations of dollars and personnel to be requested for M & O, TDY, TAD, and consultants. Form H-13 can be used to summarize the budget data.

FORM H-1

SAMPLE FORM FOR REHABILITATION ENTRY INTERVIEW

Entered for Drugs Alcohol

1. Name of client _____
2. Unit _____
3. Date of birth _____
4. Please indicate how you were identified as a drug user/problem drinker or how you entered this T/R program:

Biochemical TestingOther Methods

- | | |
|---------------------------------------|-------------------------------------|
| a. Initial entry on active duty _____ | h. Self-referral _____ |
| b. Reentry with prior service _____ | i. Medical _____ |
| c. First reenlistment _____ | j. Investigation-apprehension _____ |
| d. DEROS from RVN, Thailand _____ | k. Command referral _____ |
| e. Command directed _____ | l. Other (specify) _____ |
| f. Random unit testing _____ | _____ |
| g. Rehabilitation staff _____ | _____ |

5. If self-referral. What was the influencing factor that led you to seek T/R?

- A. A buddy _____
- B. My parents _____
- C. A teacher _____
- D. A unit commander/commanding officer _____
- E. My girl friend/wife/boyfriend/husband _____
- F. My brothers/sisters _____
- G. Priest/rabbi/minister/chaplain _____
- H. Education program _____
- I. Other (specify) _____

FORM H-1 (Continued)

6. Please indicate your pattern of drug/alcohol use before you entered this program:

Name of Drug	Last Use*	Fre-quency**	How Taken ***	Age First Use
a. Alcohol	____	____	____	____
b. Heroin	____	____	____	____
c. Other opiates	____	____	____	____
d. Cocaine	____	____	____	____
e. Methadone, as prescribed	____	____	____	____
f. Methadone, not prescribed	____	____	____	____
g. Other synthetic analgesics with morphine-like effects	____	____	____	____
h. Barbiturates	____	____	____	____
i. Darvon	____	____	____	____
j. Tranquilizers	____	____	____	____
k. Doriden	____	____	____	____
l. Other hypnotics or sedatives	____	____	____	____
m. Amphetamines	____	____	____	____
n. Other psychostimulants	____	____	____	____
o. Hallucinogens (LSD type)	____	____	____	____
p. Hashish	____	____	____	____
q. Marijuana	____	____	____	____
r. "Sleeping pills"	____	____	____	____
s. "Cough syrup"	____	____	____	____
t. Other (specify)	____	____	____	____

*Entries-Applicable Time	Code	**Entries-Applicable Frequency	Code	***Entries-Usual Method	Code
Within past 48 hours	1	Daily	1	Ingestion	1
2-7 days ago	2	Several times/week	2	Intravenous	2
2-4 weeks ago	3	Once/week	3	Subcutaneous	3
1-6 months ago	4	Several times/month	4	Smoke	4
More than 6 months ago	5	Once/month	5	Snort/Sniff	5
		Less than once/month	6	Other	6

FORM H-2
SAMPLE FORM FOR RECORDING
STAFFING FOR REHABILITATION FACILITY

Detoxification Unit
 Client Facility

Director	Military Grade	Percent of Time Alcohol	Percent of Time Drugs	Civilian Grade	Percent of Time Alcohol	Percent of Time Drugs	Remarks
General duty MD	O-4	20%					
Psychiatrist							
Psychologist							
Nurse (RN & LPN)							
Social worker (MSW)							
Social worker (BA or BS)							
Chaplain							
Counselor							
Medical technician							
Administration							
Other (specify)							

FORM H-3

SAMPLE FORM FOR MONITORING EACH REHABILITATION SESSION

1. Name of Client _____
2. Session scheduled on _____
(date)
3. Client did _____ did not _____ show
4. [If did not] Authorized excuse Yes _____ No _____
5. [If yes] Specify _____
6. [Alcohol only] client does _____ does not _____ participate in
Alcoholics Anonymous

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FORM H-3 (Continued)

Please Check

As Many As

7. Treatment Modality Applicable Title of Person Leading Session

Individual therapy		
Psychoanalysis		
Behavior or operant therapy		
Reality therapy		
Transactional analysis		
Work or Job training therapy		
Transcendental meditation		
Group therapy		
Peer group discussions		
Group marathons		
Programmed recreation		
Encounter groups		
Synanon games		
Therapeutic community techniques		
Rap center		
Detoxification		
Chaplain counseling		
On-the-job counseling		

8. Session conducted at:

Detoxification unit Out-client facility

Alcohol

FORM H-4
SAMPLE MONTHLY SUMMARY FORM FOR MONITORING REHABILITATION SERVICES

Treatment Modality	No. of Scheduled Sessions/Month	No. Actually Held	Average No. Attending Each Session	No. of Authorized Absences	No. of Unauthorized Absences
Individual therapy					
Psychoanalysis					
Behavior or operant therapy					
Reality therapy					
Transactional analysis					
Work or job training therapy					
Transcendental meditation					
Group therapy					
Peer group discussions					
Group marathons					
Programmed recreation					
Encounter groups					
Synanon games					
Therapeutic community techniques					
Rap center					
Detoxification					
Chaplain counseling					
On-the-job counseling					

FORM H-5

SAMPLE MONTHLY SUMMARY FORM FOR
MONITORING REHABILITATION: DEPENDENTS

Month of _____

Alcohol Drugs

Treatment Modality	No. Attending Each Session	For Alcohol: Number enrolled in Alcoholics Anonymous
Individual therapy		
Psychoanalysis		
Behavior or operant therapy		
Reality therapy		
Transactional analysis		
Work or job training therapy		
Transcendental meditation		
Group therapy		
Peer group discussions		
Group marathons		
Programmed recreation		
Encounter groups		
Synanon games		
Therapeutic community techniques		
Rap center		
Detoxification		
Chaplain counseling		
On-the-job counseling		

H-21

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FORM H-6

SAMPLE FORM FOR MONITORING REHABILITATION
CLIENT PROGRESS

(Fill in at the end of each month for those who spent any time in the active rehabilitation program, excluding follow-up, during that month)

Client/Patient _____

Month of _____ 19_____

1. Rehabilitation Program Status

- a. Client entered active T/R _____
(month) _____ (day) _____ 19
b. Client: left active T/R _____
(month) _____ (day) _____ 19
Still in active T/R _____
(year) _____ (year)

- c. Client still in program as:

- ____ (1) Halfway house resident
____ (2) Outclient (e.g., Rap House visitor in follow-up program)
____ (3) Hospital inpatient
____ (4) Other (specify) _____

- d. Client no longer in active T/R program or follow-up.

2. Military Effectiveness While in Active Rehabilitation to Date

- a. Number of arrests _____

- b. Number of Punishments: Article 15 _____ Other _____

- c. Commanding officer's appraisal of conduct

- ____ (1) Excellent
____ (2) Good
____ (3) Fair
____ (4) Poor
____ (5) No appraisal: Excused from normal duty.

FORM H-6 (Continued)

3. Adjustment Difficulties While in Rehabilitation to Date

- a. No known adjustment difficulties
- b. Marital difficulties
- c. Other family difficulties
- d. Social, recreational, peer group difficulties.

4. Urine Test Results While in Rehabilitation to Date

- a. Total number of tests _____
- b. Total number positive for unauthorized drugs _____

5. Estimate of Drug/Alcohol Use While in Rehabilitation to Date

- a. Frequency-current
 - (1) Frequent
 - (2) Moderate
 - (3) Occasional
 - (4) Rare
 - (5) Abstinent
- b. Frequency-change since last report
 - (1) Increased
 - (2) Diminished
 - (3) No change
- c. Change in drugs used since last report
 - (1) Not changed, still uses same drug(s)
 - (2) To opiates
 - (3) To barbiturates
 - (4) To amphetamines

FORM H-6 (Continued)

- (5) To alcohol
- (6) To other drug(s)
- (7) No longer uses drugs

6. Therapist's Opinion of Client's Progress While in Active Rehabilitation to Date

- (1) Excellent
- (2) Good
- (3) Fair
- (4) Poor

FORM H-7

SAMPLE FOLLOW-UP FORM FOR REHABILITATION CLIENTS

1. Name _____
2. Unit _____
3. Drugs _____ Alcohol _____
4. Date _____
5. Reason for leaving T/R/C:
 - (1) Rehabilitation complete: On duty
 - (2) ETS
 - (3) Honorable separation, other than ETS
 - (4) General separation, other than ETS
 - (5) Undesirable separation
 - (6) Bad conduct, dishonorable separation
 - (7) AWOL
 - (8) Discharged from T/R as unrehabilitatable
 - (9) Left on own initiative, not AWOL
 - (10) Other (specify) _____
6. Was additional rehabilitation required?
 - (1) Yes
 - (2) No

[If yes] Specify type _____
7. Were civilian rehabilitation services arranged?
 - (1) Yes: transferred to VA Hospital (name and location) _____
 - (2) Yes: civilian outpatient activity (name and location) _____
 - (3) No: patient counseled as to availability
 - (4) No (e.g., patient AWOL)

FORM H-8
SAMPLE SUMMARY FORM ON REHABILITATION PROGRAM STATUS

Month of 19

Alcohol Drugs [Complete one form for each]

Status at end of this month	Total Remaining From Previous Month	Admitted in Reporting Month	Total No. Discharged During Reporting Month	Total No. Remaining at End of Month
				4
Halfway house resident	8	/	2	7
Outclient				
Hospital inpatient				
Other (specify)				
Total				

FORM H-9

SAMPLE SUMMARY FORM ON STATUS OF PERSONS
DISCHARGED FROM PROGRAM DURING MONTH

Month of 19

Alcohol Drugs [Complete one form for each]

	Rehabilitation Complete: On Duty	EITS	Honorable Sep. Than ETS	General Sep. Other Than ETS	Undesirable Separation	Bad Conduct Dishonorable Separation	Discharged from I/R as Unrehabilit.	Left on Own Initiative Not AWOL	Other
Halfway house									
Outclient									
Hospital inpatient									
Other									
Total									

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Month of 19

Alcohol Drugs

[Check one form for each]

SAMPLE SUMMARY FORM: ADJUSTMENT AND ALCOHOL/DRUG USE DURING ACTIVE REHABILITATION

FORM H-10

Military Effectiveness While in Rehabilitation				Adjustment Difficulties While in Rehabilitation				Urine Test Results While in Rehabilitation			Estimate of Drug/ Alcohol Use While in Rehabilitation	
Number of Arrests	Number of Article 15	Other Punishment	No Known Adjustment Difficulties	Marital Difficulties	Other Family Difficulties	Social Recreational, Peer Difficulties	Total Number Positive for Unauthorized Drugs	Total Number Tests	Absentee- Rate Occasion- ally	Moderate Frequent	Rare	
Halfway house residents												
Outclient												
Hospital inpatient												
Other (specify)												

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Month of 19

FORM H-11

SAMPLE SUMMARY FORM ON CIVILIAN AGENCY FOLLOW-UP

Alcohol

Drugs [Complete one for each]

Separated from Army from	Number Separated	Number Requiring Additional Rehabilitation	Number Transferred to V. A.	Number Referred to Civilian Out Patient Facility	Number Only Counseled as to Availability	Comments
Halfway house resident						
Outclient						
Hospital inpatient						
Other (specify)						
Total						

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FORM H-12

SAMPLE INVENTORY FORM ON
REHABILITATION RESOURCES

	Spaces Allocated			
	Military		Civilian	
	<u>Grade</u>	<u>% of Time</u>	<u>Grade</u>	<u>% of Time</u>
Director				
General duty MD				
Psychiatrist				
Psychologist				
Nurse (RN & LPN)				
Social worker (MSW)				
Social worker (BA or BS)				
Chaplain				
Counselor				
Medical technician				
Administration				
Other (specify)				

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FORM H-13
SAMPLE BUDGET SUMMARY FORM

	Actual Expenditures FY 19 ____	Projected Budget FY 19 ____
Professional Staff		
Military		
Civilian		
Paraprofessional Staff		
Military		
Civilian		
M&O		
TDY		
TAD		
Consultants		
TOTAL		

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APPENDIX I

MEASURING RESULTS: EDUCATION

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APPENDIX I

MEASURING RESULTS: EDUCATION

This appendix describes ways of determining whether programs for alcohol and drug education are meeting the objectives set for them. It assumes that the programs are aimed at two target groups: (1) potential and actual drug users and problem drinkers (the entire population of the post) and (2) the leadership structure. For additional discussion of the evaluation of drug education (in this case, drug education in the schools), see Accountability in Drug Education, edited by L. Annette Abrams, Emily F. Garfield and John D. Swisher (Washington, DC: The Drug Abuse Council, 1973).

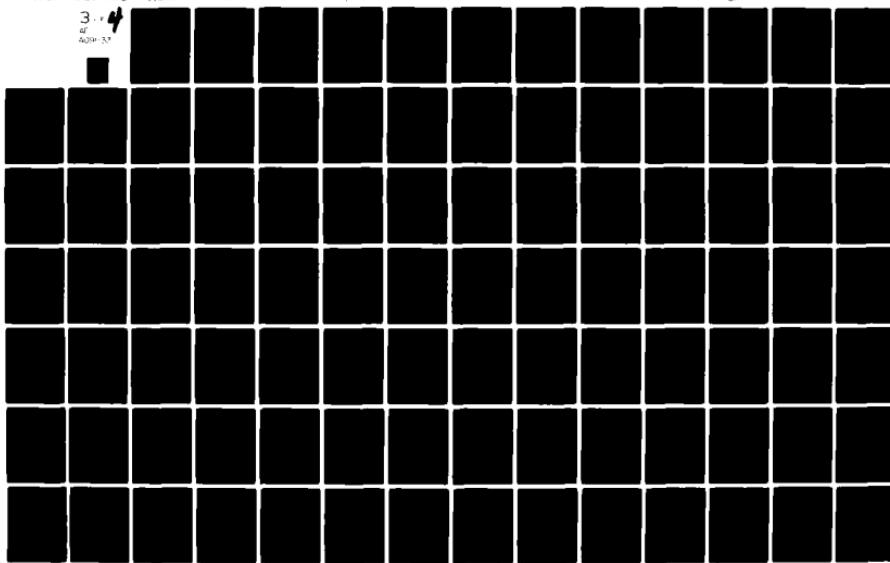
1. INFORMATION SOURCES FOR EVALUATION

The evaluation can be based partly on tests administered to members of the target populations. The sample test instrument for potential and actual users/abusers (Form I-1) at the end of this appendix includes questions addressing each of the three possible basic objectives of alcohol/drug education: to improve or reinforce knowledge about alcohol and drugs and their effects, to develop new attitudes or reinforce old attitudes concerning drugs and alcohol, and to change behavior of substance abusers or reinforce nonabuse behavior. The sample test instrument for the leadership structure (Form I-2) focuses on knowledge and attitudes.

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For a given target group, the evaluation should rely mainly on those questions addressed to the basic objective or objectives chosen for that group. Where this/these include behavior change, data from the post records can be used in addition to the survey questions. These records (number of substance abusers identified, etc.) may provide more reliable information on actual behavior than can be obtained from the survey responses. Data collection and summary forms (Forms I-3 and I-4) follow the test instruments at the end of this appendix.

The design of an experimental structure by administering the survey is discussed below. Records could be reviewed by random selection over a period of time or by looking at every soldier's record at specific times.

2. EXPERIMENTAL DESIGN

a. Introduction

The term experiment, as used here, refers to a formal process using a random sample of individuals from the target population, by which a program can be systematically compared to other programs or to the complete absence of formal programs. Experiments can save time and money by enabling one to evaluate a program or several alternative program modalities without exposing the entire population to them.

For purposes of an experiment to evaluate education programs, a random sample should be obtained of individuals who either have been exposed to approximately equal amounts of previous alcohol/drug education on the post or have not been exposed to any. Section 2 of

Appendix D describes methods of obtaining a random sample. If the ADAPCP has readily retrievable ordered files or lists of those who have not had alcohol/drug education prior to your program or who have had comparable amounts of education, the easiest of these methods to use is systematic random sampling. If the experimental design involves both an experimental group and a control group, two groups need to be randomly selected, using the same method for both.

In designing an experiment one should bear in mind three primary criteria for good design:

- The measuring device should be appropriate to the program.
If, for example, one of the questionnaires accompanying this appendix is modified for use, those questions should be chosen which relate to the basic objective or objectives of the program (knowledge, attitude change, behavior change).
- The measuring device should be administered to a representative sample of the target population. That is, the selection process should be such that each person in the target group has an equal chance of being selected for measurement, the objective being to create a test sample which reflects all of the relevant characteristics of the total population -- age, sex, rank, etc.
- The experiment is such that it will measure the results of the program and minimize external effects (e.g., peer group relationships). This criterion will become more clear in the discussion of alternative designs.

The experimental designs discussed here are arranged in order of

preference (ideal), in terms of satisfying the three design criteria. Each experiment has pitfalls which should be kept in mind when it comes time to analyze the results. The selection of a particular experiment type will have to depend partly on the restrictions which the post environment might place on the program. For example, it may not be possible to conduct more than one kind of education program (for comparative purposes) at a time because of resource (dollars, instructors) or time constraints.

For the sake of brevity, the following symbols will be used in each experiment design example:

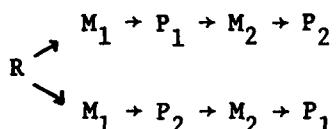
- P₁ experimental program (the program being evaluated)
- P₂ control program (another program, used for comparison)
- P experimental program where there is no control program
- R random assignment of personnel into an experimental or control group
- M test or measurement of a program
- M₁ pretest (before program)
- M₂ post-test (after program)
- M₃ post-test (after program)
- "followed by"

Before proceeding, it is important to remember that in experiments using a control group, the random assignment should be such that the control group is selected in the same way as the experimental group, except that it is not exposed to the program being measured.

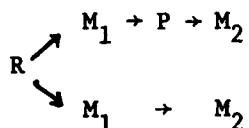
Four possible evaluation designs are discussed below, in order of preference.

b. The Pretest/Post-Test Control Group Design

In this design, both the experimental group and the control group are tested before as well as after the program is conducted. It may take one of two forms depending on whether the control group is given a substitute education/prevention program or no program at all during the time of the experiment.



or



The first design involves an experimental program and a substitute program and has both the experimental group and the group group eventually exposed to both programs. The second design involves an experimental program with no substitute program. That is, the control group is given no formal education program.

These experimental designs have two basic advantages:

- (1) The use of a control group enables one to distinguish effects of the experimental program from changes that happen anyway over the time period covered by the experiment.
- (2) The use of a pretest allows one to measure the amount of change in each group instead of simply comparing the two groups after the program. This eliminates any effects due

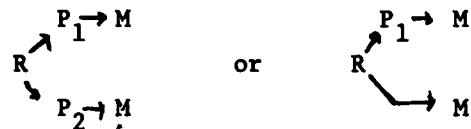
to possible initial differences in knowledge, attitudes, or behavior of the two groups.

When the design is such that the control group receives no program, it has the additional advantage of enabling one to measure external effects (such as peer group relationships) on the knowledge, attitudes, and behavior of the control group.

There is a pitfall which should be kept in mind should this experiment type be chosen. This is the possibility that the pretest will influence the results by causing participants to behave differently from the way they might have behaved had there been no pretest.

c. The Post-Test Control Group Design

In situations where it can be safely assumed that the experimental and control groups are equal in their knowledge, attitudes, and behavior before the project begins, the pretest may be dispensed with.



In this design the control group may receive either a substitute program or no program. The primary advantages of this design are that it is simpler to administer than those involving pretests and there is no chance for a pretest influencing the outcome. The primary disadvantage is that one could be mistaken in assuming that the two groups are matched in terms of prior knowledge, attitudes, and behavior. Differences between the groups can affect inferences drawn from the program results. For instance, if the control group is initially more knowledgeable than the experimental group,

even a superior program may appear to have produced insignificant changes in knowledge. Fortunately, major differences are rare if proper random selection procedures are followed in choosing the groups.

d. The Single Group (no control group) Pretest/Post-test Design

In situations where it is impossible to create control groups the alcohol and drug education researcher is left with design alternatives which are not as effective as those we have discussed.

$$M_1 \rightarrow P \rightarrow M_2$$

The advantage of this design, in comparison with the design that follows, is that it provides information about prior knowledge, attitudes, and behavior through the use of the pretest. The important disadvantage is that, without a control group, the researcher does not know for sure whether any change shown by the post-test has been caused by the program or other factors.

e. The Single Group (no control group) Post-test Design

The least desirable design is this one, which has neither a control group nor a pretest.

$$P \rightarrow M$$

The post-test shows only whether or not the group is exhibiting the desired knowledge, attitudes, or behavior. It does not show whether this is in any way due to the program.

3. HOW TO TEST EACH GROUP

Given the need for anonymity, self-administered questionnaires are probably preferable to interviews as an approach to testing.

a. The Setting

The tests should be administered to large groups (for maximum anonymity) overseen by someone from the ADAPCP office. Respondents should be urged to be complete in their responses and should be informed that each questionnaire will be checked for completeness. To distinguish responses of the experimental group from those of the control group the tests should be given out separately and the questionnaires numbered differently for the two groups; for example, the questionnaires given to experimentals could have numbers in the 1000's, while the controls could have numbers in the 2000's.

Rooms for the group self-administered questionnaire should be large enough so that no respondent can see the responses of anyone else. Each respondent needs a surface for placing the questionnaire and checking responses, a seat, and adequate lighting. The room should be comfortably heated or ventilated, depending on the season. It should be reasonably insulated from noise distraction outside.

b. Conditions

Anonymity must be preserved for all respondents. There should be no question asked which would identify respondents; at the end of the evaluation, the lists of respondents should be destroyed.

c. Approach

The discussion here and under d and e below, is intended as a guide to either modifying the sample test instruments (I-1 and I-2) for the purposes of the particular ADAPCP or designing new test instruments.¹

The test questions should be mostly "closed end," so that respondents can check off their answers rather than writing them. This makes for precise responses and also facilitates the process of computer entry and interpretation. Since everyone is asked to respond to all questions, each question must allow for answers by all respondents; categories like "none of the above" or "does not apply" will sometimes be necessary. Space should be left at the end to allow soldiers to write in any comments they might have, and those checking an "other" category should be asked to specify what the "other" is, but the rest of the questionnaire should be closed-end.

Questions should follow a logical pattern so the train of thought is easy to follow. Generally speaking, questions should be in a "funnel" order -- going from general to more specific. Sensitive questions should not be placed at the very beginning of the questionnaire. In changing topics, a transitional sentence helps -- e.g., "Now, a few questions about yourself."

Language should be simple and easily understood. Since people often have different frames of reference for words; care should be taken to define any such words which are going to be used. For example, many schools give some sort of drug education, so it must be made clear that the term "drug education" is used to refer to Army drug education.

Questions should be asked in such a manner that all answers are seen

1. See also Leon Festinger and Daniel Katz, eds., Research Methods in the Behavioral Sciences (New York: Holt, Rinehart and Winston, 1953), pp. 340-353; Claire Sellitz, Marie Jahoda, Morton Deutsch, and Stuart W. Cook, Research Methods in Social Relations, (New York: Holt, Rinehart and Winston, 1959), pp. 255-263.

as equally probable. While this is most critical in an interview, it nonetheless holds true for a questionnaire, since respondents do pick up subtle clues as to what answers are expected and may bias their responses accordingly. For example, instead of saying, "Do you think someone caught using drugs should be dishonorably discharged from the Army?" one can say: "Some people have said that a person caught using drugs should be dishonorably discharged from the Army. Do you agree, disagree, have no opinion, or think it depends on the circumstances?"

As discussed in Section 3-c of Appendix D, questionnaires should be pre-coded and can be either of the mark sense or the keypunch variety. The layout should look clean and uncluttered and should be easy to follow. It is advisable to use two kinds of type, such as roman and italic -- one for questions and one for instructions. A question should not be split between two pages unless it takes up more than a full page.

It is often useful to make consistency checks. These consist of checks to make sure responses are consistent throughout the questionnaire. For example, one can ask about drug use in one place, and then later ask questions relying on the earlier data. Thus, question 10 might ask about specific experience with various kinds of drugs, and question 41 might ask, "For each drug you have ever tried, please indicate whether or not you presently use that drug," and might include the possible response "does not apply -- never used." Responses to questions 10 and 41 could then be compared for consistency. Inconsistent responses are a reminder that the test results, while collectively a valid measure of program effectiveness, may not in all cases be individually accurate.

Bias refers to the fact that fatigue and other factors such as a tendency to agree with statements consistently may work against a correct response. To avoid this, questions which ask for agree-disagree type responses, for example, should be divided between positively worded and negatively worded statements.

For sensitive questions, sanctioning statements help to ease socially unacceptable responses. A classic example is in questions about voting, where rather than asking, "Did you vote in the last election?" the questioner says: "Many people didn't get a chance to go to the polls in the last election. Did you happen to go to the polls, or not?" In some instances the issue may be sufficiently sensitive that it needs to be asked in the third person as if it referred to people in general or an unspecified individual rather than to the respondent himself.

Responses should include large enough intervals so that respondents feel "protected", for example, income should generally not be grouped in \$1000 intervals. Also, in questions about income or education no one wants to be in the lowest group, so the first grouping should be low enough to exclude nearly everyone (for example, under \$3000).

The questionnaire needs an introduction and a set of instructions; the former gives information about why the survey is being conducted and what will be done with the data (stressing anonymity). The latter informs the respondent about how to proceed.

The questionnaire is typically in booklet form, printed on both sides of the page.

d. Types of Question

As noted above, the purpose of the questions is to determine to what extent changes/reinforcement of knowledge or attitudes or behavior have resulted from drug/alcohol education programs. Questions of all three kinds have been included in the sample test instruments.

There are a number of ways of asking questions, particularly attitudinal ones. Many techniques are available, from agree/disagree scales to the semantic differential, which asks respondents to place themselves along a spectrum bounded by extreme opinions, for instance:

Attitudes toward drug use here at this post are:

strong _____ weak

Users should be punished _____ users should
not be punished

Etc.

In the spectrum type of question it is a good idea to have enough response choices (for instance, 5 rather than 3) so that respondents can express an opinion without being at the extreme end of the scale.

Whole books and chapters are devoted to the measurement of attitudes, and anyone designing a questionnaire for this purpose would do well to review some of that material.¹

1. See, for example, John P. Robinson and Phillip R. Shauer, Measures of Social Psychological Attitude, (Ann Arbor: Survey Research Center, University of Michigan, 1969), and Sellitz, op. cit., pp. 243-55; 276-314; 343-384. See also Inventory -- Drug Abuse Research Instrument (Cambridge, Mass., January 1972); Research Reference Files; and ERIC Clearinghouse for Tests, Measurements, and Evaluation.

e. The Trial Pretest

Before a questionnaire is administered to a respondent sample, it should be tested with a small number (5-10) of respondents in each group (known substance abusers, potential abusers, leaders) under the actual conditions of the survey. At the conclusion, the staff member administering the questionnaire should review the questions with each respondent, asking him to point out questions that were confusing or response categories that were confusing, misleading, or inappropriate. The questionnaires can then be revised, printed, and made ready for the survey.

4. USE OF POST RECORDS

An important information source for assessing behavior change consists of post records of disciplinary actions, confirmations, participation in exemption/rehabilitation programs, transfers, and discharges. Records should be reviewed for persons exposed to the program and those not exposed.

5. WHAT TO DO WITH THE TEST RESULTS

As discussed in Appendix D, Section 4, the first step after the questionnaires have been filled out is to go through them, check for double answers and other problems, do a computer "edit," and run straight tabulations showing the number and percent of respondents checking each response item.

a. Cross-Tabulations and Scales

Cross-tabulations of the data can then be run. These can be of several types, including responses by background data (e.g., age, marital status),

consistency checks (response to one question by response to another), cross-tabulations of one attitude against another; cross-tabulations of attitudes against behavior, and cross-tabulations of one behavior against another. One sample could also be compared to another--e.g., leaders to soldiers--in terms of knowledge, attitudes, or perceived behavior. In addition, the types of data involved here lend themselves to scales.

Table I-1 shows examples of cross-tabulations and scales.

TABLE I-1

EXAMPLES OF CROSS-TABULATIONS AND SCALES

1. Response by Background Data

Whether or not respondents say that education is effective in stopping any use, by sex of respondent

<u>Effective?</u>	<u>Male</u>	<u>Female</u>
Yes	X	X
No	X	X
Don't know	X	X

2. Consistency Check

Whether or not received education
by no. of hrs. education received in Army

<u>Received education</u>	<u>Hours received</u>	
	<u>None</u>	<u>One or more</u>
Yes	---	X
No	X	---

3. One Attitude versus Another

Opinion of material covered in education by opinion
of time devoted to drug education

<u>Material should be</u>	<u>Time devoted to education</u>				
	<u>About right</u>	<u>Too much</u>	<u>Too little</u>	<u>Eliminated</u>	<u>DK</u>
Changed					
Same					
Don't know or no opinion					
Not applicable					

TABLE I-1 (Continued)

4. Attitudes versus Behavior

<u>Things good about education</u>	<u>Attitude toward education by effect on use of drugs*</u>					
	<u>Not applicable</u>	<u>No effect</u>	<u>Stay off</u>	<u>Stop</u>	<u>Cut down</u>	<u>(Etc.)</u>
Not applicable						
Accurate						
Truth						
Balanced						
Powerful						
Confirmed experience						
Open-minded						
Alternatives						
Nothing						
Other						

5. Behavior versus Behavior

Effect on use of drugs, by alternatives used more*

<u>Effect</u>	<u>Not applicable</u>	<u>Religion</u>	<u>Hobbies</u>	<u>Sports</u>	<u>Recreation</u>	<u>(Etc.)</u>
Not applicable						
None						
Stay off						
Stop						
Cut down						
Switch down						
Start						
Restart						
Increase						
Switch up						

* Because of the number of items, either large sample sizes would have to be used, or the categories would have to be grouped.

TABLE I-1 (Continued)

6. Scale

Knowledge scale*

Take each of the 63 questions testing knowledge and score each individual's responses as follows:

0 = no right answer

1 = partially right/partially wrong

2 = partially right/no wrong answer

3 = all right

Then: Add up scores, and divide respondents into three groups:

high knowledge, moderate knowledge, low knowledge.

* The scale could then be cross-tabulated against other items. Scales are appropriate for knowledge, attitudes, and behavior.

b. Interpreting the Results: Chi-Square (χ^2) Tests

Once the data have been tabulated in terms of frequency counts and cross-tabulations, it remains to analyze the data; that is, interpret the results by applying statistical estimation and testing techniques which lead to valid inferences and conclusions about the population group from which the sample has been taken. The objective of the analysis is to gain insight into the drug and alcohol problem and the effect of the education program, in order to improve the program. To draw conclusions about the program from the test results, however, one needs to be able to determine the statistical significance of the observed relationships between variables in the cross-tabulations. That is, one needs a way of telling whether variables (such as attitude toward the education program and drug use) are independent of one another or whether they are related.

An effective technique for determining statistical significance is provided by the Chi-square (χ^2) test.¹ In this application, the Chi square (χ^2) test statistic is used to determine whether two variables are statistically independent. An example similar to the cross-tabulation examples above is used here to demonstrate the Chi-square technique. The explanation is intended to be understood by a reader who has some mathematical background but no statistics. If the ADAPCP has access to someone with a statistical background, however, it is simpler to have that person do the analytic work, with guidance from the ADCO as to the information sought.

1. For a discussion of theory, see Bernard Ostle, Statistics in Research (Ames, Iowa: Iowa State College Press, 1956).

Suppose that program staff wish to determine whether an experimental drug education program has been more effective than a traditional program in terms of ameliorating the drug use problem on the post. Suppose, further, that they had previously determined that length of service at a post was a factor in drug use -- the longer the length of service, the greater the drug problem. And finally, suppose that they have conducted an experiment with two groups of soldiers randomly selected among those whose service length on the post was greater than 12 months: one group a control group to receive the traditional education program; the other group an experimental group to receive the experimental program.

At the conclusion of both programs, a contingency table (cross-tabulation) could be constructed from questionnaire results, as shown in Table I-2. Each of the boxes in this table where a value has been entered is called a "cell." (In cases where a cell turns out to have a value of less than 5, adjacent cells should be combined to create a broader class. This problem does not arise with Table I-2.)

TABLE I-2

CONTINGENCY TABLE SHOWING EFFECT OF
EXPERIMENTAL EDUCATION PROGRAM

Sample of 900 Soldiers on the Post
More than 12 Months

Drug Use	Traditional Program (B_1)	Experimental Program (B_2)	Total
(A ₁) Drug Users	140	160	300
(A ₂) Non-Users	260	340	600
TOTAL	400	500	900

At a glance it appears from Table I-2 that there is a relationship between the program type and drug use; apparently, there are relatively fewer users among those receiving the experimental program than among those receiving the traditional program (32% vs. 35%). However, to actually establish a dependency between the variables (education program and drug use), it is necessary to develop the appropriate test statistic in order to reach one of two possible inferences:

- I₁ Program participation and drug use are statistically independent
- I₂ Program participation and drug use are not statistically independent (that is, they are strongly related, since a relationship that is only slight will show up as "independent" in the calculations).

A step-by-step procedure for calculating the test statistic follows. Note that the values in each cell of the contingency table are the actual sample counts of drug use/non-use relative to the two education programs. In the calculations which follow, estimates are made of the expected counts, or frequencies, if, in fact, inference I₁ is true; that is, education program and drug use are independent.

Step 1: Compute the expected frequencies for each cell in the table by multiplying a cell's row total by its column total and dividing by the sample (grand) total.

For example, the expected frequency of the cell containing drug users who received the traditional program (A₁, B₁) is computed as follows:

$$\frac{(300)(400)}{900} = 133$$

Step 2: Insert the expected frequency along with the actual count. In the example below the expected frequencies are circled.

Drug Use	Traditional Program (B ₁)	Experimental Program (B ₂)	Total
(A ₁) Drug Users	140 133	160 167	300
(A ₂) Non-Users	260 267	340 333	600
TOTAL	400	500	900

Step 3: Calculate the test statistic (V) using the "Calculation of Test Statistic for Statistical Independence" shown in Table I-3.

TABLE I-3
CALCULATION OF TEST STATISTIC FOR STATISTICAL INDEPENDENCE*

Joint Classification	Sample Count (f _s)	Expected Frequency (f _e)	Deviation (f _s -f _e)	Squared Deviation (f _s -f _e) ²	Relative Squared Deviation (f _s -f _e) ² /f _e
A ₁ and B ₁	140	133	7	49	.386
A ₁ and B ₂	160	167	-7	49	.293
A ₂ and B ₁	260	267	-7	49	.184
A ₂ and B ₂	340	333	+7	49	.147
	900	900	0		V = .992**

* Entries in the first 3 columns are from the contingency table; the rest are calculated from these.

** The formula for this calculation reads

$$V = \sum \frac{(f_s - f_e)^2}{f_e} = .992 \quad (\Sigma \text{ means "the sum of"})$$

Step 4: Compare the test statistic (V) to a Chi-square (χ^2) distribution with $(R-1) \times (C-1)$ degrees of freedom.

As explained below, R and C refer to the number of rows and columns in the contingency table, I-2.

Chi-square (χ^2) distributions are shown in Table I-4.

The theory of this analysis will not be detailed here.

It is sufficient for present purposes to say that statistical theory shows that for the type of problem under consideration, if I_1 is true (that is, if type of education program and drug use are independent), the test statistic (V) will be equal to or less than a Chi-square distribution with $(R-1) (C-1)$ degrees of freedom, where,

R = the number of classes (rows) into which one of the variables is classified;

C = the number of classes (columns) of the other variable.

To conclude this step it is necessary to:

- a. Compute the degrees of freedom, $(R-1)(C-1)$. The contingency table has two rows and two columns, so $R=2$ and $C=2$. Thus, $(R-1)(C-1) = (2-1)(2-1) = 1$.
- b. Determine the acceptable level of risk that the conclusion will be erroneous. The usual practice is to tolerate a risk (or chance of error) of .05. This means that the chance is only 1 in 20 that the calculations will show I_2 to be correct when in fact I_1 is correct; that is, the chance is only 1 in 20 that the two variables will appear to have a statistically significant relationship when they are really independent. Note that the Chi-square (χ^2) distribution table, Table I-4, displays risk levels of .01 (1 in 100), .02 (2 in 100), .05 (1 in 20), and .10 (1 in 10). In this discussion, the conventional one, .05, is used.
- c. Read the Chi-square value from the table using the appropriate degrees of freedom (in this case, 1) and an assumed .05 risk of error.
In the example, $\chi^2 = 3.841$.
- d. Set up a decision rule as follows:

If $\chi^2 \leq 3.841$, conclude I_1 (education program and drug use are independent).
If $\chi^2 > 3.841$, conclude I_2 (education program and drug use are not independent); that is, the data indicate a strong relationship.

TABLE I-4
TABLE OF χ^2 DISTRIBUTION

Degrees of Freedom	Risk Levels			
	.10	.05	.02	.01
1	2.706	3.841	5.412	6.635
2	4.605	5.991	7.824	9.210
3	6.251	7.815	9.837	11.341
4	7.779	9.488	11.668	13.277
5	9.236	11.070	13.388	15.086
6	10.645	12.592	15.033	16.812
7	12.017	14.067	16.622	18.475
8	13.362	15.507	18.168	20.090
9	14.684	16.919	19.679	21.666
10	15.987	18.307	21.161	23.209
11	17.275	19.675	22.618	24.725
12	18.549	21.026	24.054	26.217
13	19.812	22.362	25.472	27.688
14	21.064	23.685	26.873	29.141
15	22.307	24.996	28.259	30.578
16	23.542	26.296	29.633	32.000
17	24.769	27.587	30.995	33.409
18	25.989	28.869	32.346	34.805
19	27.204	30.144	33.687	36.191
20	28.412	31.410	35.020	37.566
21	29.615	32.671	36.343	38.932
22	30.813	33.924	37.659	40.289
23	32.007	35.172	38.968	41.638
24	33.196	36.415	40.270	42.980
25	34.382	37.652	41.566	44.314
26	35.563	38.885	42.856	45.642
27	36.741	30.113	44.140	46.963
28	37.916	41.337	45.419	48.278
29	39.087	42.557	46.693	49.588
30	40.256	43.773	47.962	50.892

From R. A. Fisher, Statistical Methods for Research Workers
 (Edinburgh: Oliver and Boyd, 1934-1944).

In the example $V = .992$. One can therefore conclude that education program and drug use are independent (I_1). In other words, the experimental program does not significantly affect drug use in comparison with the traditional program. Note by looking at Table I-4 that at 1 degree of freedom and an error risk of .10, the χ^2 value obtained would be 2.706. Thus one would reach the same conclusion by running the risk of being in error 1 in 10 times.

c. Interpreting the Results: t-Tests

In addition to Chi-square (χ^2) tests for contingency as described above, there are other useful statistical techniques. One that is particularly appropriate for before-and-after situations such as those involved in program evaluation is the t-test to measure equality of means. The t-test enables one to determine whether the difference between two averages is statistically significant. Suppose, for example, that one wants to determine whether or not the average level of knowledge, as determined by a test questionnaire and measured on the knowledge scale in Table I-1, has increased as a result of the educational program. Formulating the problem in statistical terms, one wants to test the hypothesis that the average knowledge of personnel after drug/alcohol education is no different from the average before completing the program. To perform this test, results of the two sets of sample data (before and after) are utilized to compute a test statistic. The value of this statistic is then compared to a theoretical value (see Table I-5) based on the assumption that there is, in fact, no difference between the two data sets. If the test statistic computed from the data is greater than the theoretical (tabular) value, the hypothesis is rejected and one can conclude that a significant change in the knowledge level has occurred.¹

To illustrate the concept of testing for equality of means, suppose that a random sample of 6 persons, tested at the start of a drug education program,

¹Underlying assumptions and computational procedures required to perform tests of the equality of means are described in most statistical methods texts; for example, see Bernard J. Ostle, Statistics in Research (Ames, Iowa: Iowa State College Press, 1956) or Irwin Miller and John E. Freund, Probability and Statistics for Engineers (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1965).

was observed to have relatively little knowledge (see the last example in Table I-1) about drugs and alcohol. Furthermore, suppose that another random sample of 7 persons, who had just completed the program, obtained rather high scores on the knowledge scale. (In reality, sample sizes would be much larger; however, small samples are used here to illustrate computational techniques.) As a consequence, it would be of interest to determine whether the differences in scores on the knowledge scale are "random" in the sense that they can normally be expected from two samples from the same population, or whether they are significantly different in the sense that the two sample groups actually exhibit different knowledge levels. The t-test is a statistical procedure that can be used to resolve this issue.

The computational procedure can be illustrated with the following data:

KNOWLEDGE SCALE
VALUES FOR EACH PERSON

<u>Sample Group</u> <u>Prior to</u> <u>Education</u> <u>Program</u>	<u>Sample Group</u> <u>Completing</u> <u>Education</u> <u>Program</u>
30	35
25	30
31	34
28	33
30	34
31	29
	31

To perform a t-test to see if the two groups differ in terms of knowledge scale, the following three quantities must be calculated:

- (1) Average knowledge score for the first sample group

(\bar{x}_1):

$$\frac{30 + 25 + 31 + 28 + 30 + 31}{6} = 29.17$$

- (2) Average knowledge score for the second sample group:

$$\frac{35 + 30 + 34 + 33 + 34 + 29 + 31}{7} = 32.28$$

- (3) Measure of the variability of the data, designated as the pooled estimate of the common variance: (s^2) . This is calculated as follows:

- (a) Take the knowledge score for each person in group 1 and subtract the average value (\bar{x}_1), then square the result. Example: $(30-29.17)^2 = 0.69$.
 - (b) Add results for all 6 persons.
 - (c) Repeat for group 2 using the average value (\bar{x}_2).
 - (d) Add together all the results for the two groups.
 - (e) Divide by the following quantity: number of persons in group 1 plus number of persons in group 2 minus number of groups.

Thus:

$$= \frac{\left[(30-29.17)^2 + (25-29.17)^2 + \dots + (31-29.17)^2 + (35-32.28)^2 + (30-32.28)^2 + \dots + (31-32.28)^2 \right]}{6+7-2}$$

$$= \frac{26.83 + 31.43}{11}$$

$$= 5.29$$

Next, the test statistic is calculated as follows:

$$t = \frac{\bar{x}_1 - \bar{x}_2}{\sqrt{\frac{s_1^2}{n_1} + \frac{s_2^2}{n_2}}}$$

where n_1 is the number of observations in the first group, and n_2 is the number of observations in the second group.

Thus, in this example,

$$t = \frac{32.28 - 29.17}{\sqrt{\frac{5.29}{6} + \frac{5.29}{7}}} = \frac{3.11}{\sqrt{1.637}} = 2.43$$

If one is willing to risk being wrong no more than 5% of the time (that is, test at a 5% significance level), the computed value of 2.43 is compared with the appropriate tabular value given in Table I-5.

TABLE I-5

t-TABLE AT 5% RISK

Degrees of Freedom	Tabular t-Value
1	12.706
2	4.303
3	3.182
5	2.571
10	2.228
11	2.201
20	2.086
50	2.008
100	1.984
500	1.965

Expanded tables appear in most statistical texts, but Table I-5 is sufficient to demonstrate the method.

In order to look up the proper value in Table I-5, one needs to know the degrees of freedom as well as the risk level. For problems involving two groups, degrees of freedom are $(n_1 + n_2 - 2)$, or 11 in this case. Thus, the tabular value of interest is 2.201. This is smaller than the computed t-value, indicating that the difference between the two groups is statistically significant rather than random. The interpretation of this result is that the computed value of 2.43 is very unlikely to occur (that is, with less than a 5% chance) if, in fact, the two groups are no different in terms of knowledge scores. Thus, it could be concluded that the educational program has had a favorable effect on the participants in terms of improving their knowledge about drugs and alcohol.

Other standard statistical methods, such as regression and correlation analysis, should be applicable for interpreting the data. These and other techniques, far too numerous to describe in this report, are described in detail in the texts that have been cited.

6. QUESTIONS TO BE ANSWERED FROM THE EXPERIMENT, RECORDS, AND OTHER SOURCES

In performing the statistical work described above and using available post records to amplify or correct the results, you need to have in mind a set of questions to be answered. Examples of such questions are given below:

I. What is the extent of drug and alcohol education on this post?
(From the program monitoring data obtained as described in
Appendix G)

II. What is the nature of the education program on this post?
(From program monitoring data)

III. What effects, if any, has the program had on this post?

- A. Knowledge improvement
 - Enlisted men (Test results)
 - Officers (Test results)
- B. Attitude change
 - Enlisted men (Test results)
 - Officers (Test results)
- C. Behavior change
 - Enlisted men (Test results, plus post records for experimental and control groups)
 - Officers (Test results)

IV. What factors, if any, differentiate those who change alcohol abuse and drug use after education from those who do not? (Test results)

- Age
- Length of time in service

- Length of time at post
- Pay grade
- Initial drug/alcohol use
- Marital status
- Type of unit

V. What are the attitudes toward the education program?

- For enlisted men (Test results)
- For officers (Test results)

VI. What factors, if any, differentiate those who hold one attitude versus another? (Test results)

7. SAMPLE FORMS

On the following pages are sample test questionnaires (Form I-1 for known and potential substance abusers and Form I-2 for leaders) and data collection instruments for post records (Form I-3 for recording data on individuals and Form I-4 for summarizing data by experimental group versus control group).

FORM I-1

A SAMPLE QUESTIONNAIRE FOR BOTH EXPERIMENTAL AND CONTROL SOLDIERS
AND ADMINISTERED AFTER COMPLETION OF THE DRUG/ALCOHOL EDUCATION
PROGRAM FOR EXPERIMENTALS: KEYPUNCH VERSION.¹

DRUG AND ALCOHOL SURVEY

WHAT THIS IS ABOUT

We are trying to find out about drug and alcohol education and the use of drugs and alcohol at this post. You are one of about _____ soldiers filling out this survey.

This questionnaire is for you to fill out anonymously. You cannot be identified, because you are asked not to sign your name. DO NOT SIGN YOUR NAME OR SOCIAL SECURITY NUMBER ANYWHERE ON THE QUESTIONNAIRE.

This survey is not for or against drugs and alcohol. Its only purpose is to get facts, opinions, and attitudes about drugs and alcohol and drug

1. For mark sense version, add the following instructions under WHAT TO DO:

Marking Directions: Your responses will be read by an optical mark reader. Your careful observance of these few simple rules will be most appreciated.

- Use only the black lead pencil you have been given.
- Make heavy black marks that fill the circle.
- Erase cleanly any answer you wish to change.
- Make no stray markings of any kind.

Example: 1. Are marks made in black pencil the only type the optical reader will recognize?

- Yes
- No

FORM I-1 (Continued)

and alcohol education programs. Unless the question asks otherwise, we are talking drug use without a prescription.

Your honest answers to this survey will help soldiers who have alcohol or drug problems, now and in the future. Facts learned from this survey will help the post to develop better programs of alcohol and drug education.

Instructions for answering the questions are given below. Read them carefully before you begin.

Thanks. We appreciate your help.

WHAT TO DO

You can answer most of the questions below by making a check mark. Ignore the numbers in italics. They are for computer use only. Make one answer to each question, unless the question says, "Check as many as apply." In a few questions, we ask you to explain or specify an answer or fill in a number. Answer all the questions honestly and carefully. There is no time limit, so take as much time as you need.

Questionnaire No.

(1) (2) (3) (4)

First, we'd like to know about your exposure to drug/alcohol education programs. Drug/alcohol education is the means by which somebody in an official capacity informs you about drugs and alcohol, why people use them,

FORM I-1 (Continued)

what they can do to and for you, what you ought to do about them, what the Army will do to help people who have alcohol or drug problems, or what to do about other people who have them. This can be done by lecturing to you, leading a discussion, showing you a movie, giving you material to read, or answering your questions. It does not include what happens in treatment/rehabilitation programs for known drug users or problem drinkers.

1. Where, if anywhere, have you received drug/alcohol education in the Army? (Check as many as apply) (5)

- 1. Never received drug/alcohol education
- 2. Basic combat training
- 3. One or more posts I was stationed at after basic combat training, before the present one
- 4. This post

2. All told, about how many hours of drug/alcohol education have you received since you came into the Army? (Check only one) (6)

- 1. None 4. 5-6 7. 11-14
- 2. 1-2 5. 7-8 8. 15 or more
- 3. 3-4 6. 9-10 9. Don't remember

3. About how many hours of drug/alcohol education have you received at this post? (Check only one) (?)

- 1. None 4. 5-6 7. 11-14
- 2. 1-2 5. 7-8 8. 15 or more
- 3. 3-4 6. 9-10 9. Don't remember

FORM I-1 (Continued)

4. Do you have a Drug Education Specialist (DES) for your unit
(company or battalion)? (Check only one)

1. Yes. 2. No 3. Don't know

(8)

5. Which of the following activities, if any, have you participated
in on this post as part of the drug/alcohol education program?
(Check as many as apply)

1. Doesn't apply--never had drug/alcohol education at this post (9)

2. Literature about drugs (books, pamphlets, etc.)

3. Classes or lectures about drugs

4. Discussions or rap sessions about drugs

5. Rap centers or drop-in

6. Movies or slide shows

7. Posters

8. Talk by former drug users/problem drinkers

9. Command information

1. Role playing

(10)

2. Field teams

3. Plays, road shows, or skits put on by the drug program

4. Other (specify) _____

5. Don't recall

FORM I-1 (Continued)

6. Which, if any, of the following kinds of people have presented drug/alcohol education to you formally or informally at this post (not including people who were working with you as part of a drug/alcohol treatment or rehabilitation program)? (Check as many as apply)

1. Doesn't apply--never had drug/alcohol education at this post (11)
2. Officer from the drug/alcohol program on the post
3. Enlisted man from the drug/alcohol program on the post
4. Someone from the post's law enforcement group, carrying out drug/alcohol education
5. Chaplain/clergy carrying out drug/alcohol education
6. Social worker carrying out drug/alcohol education
7. Psychologist carrying out drug/alcohol education
8. Physician/psychiatrist carrying out drug/alcohol education
9. Officer from my unit, responsible for drug/alcohol education
1. Enlisted man from my unit, responsible for drug/alcohol education (12)
2. Commanding officer of my unit, talking formally or informally about drugs/alcohol
3. NCO from my unit, talking formally or informally about drugs/alcohol
4. Former drug users/problem drinkers
5. Other (specify) _____

FORM I-1 (Continued)

7. Which, if any, of the following kinds of people would you go to, to talk about alcohol and drugs. (Check as many as apply)

1. Doesn't apply--don't use alcohol/drugs (13)
2. No one
3. Friend
4. Doctor
5. Former drug user/problem drinker
6. Present drug user/problem drinker
7. Chaplain/clergy
8. Psychologist
9. Psychiatrist
1. Drug Education Specialist in my unit (14)
2. Social worker
3. MP's/Provost Marshal
4. Commanding Officer of my unit
5. Senior NCO in my unit
6. Other (specify) _____

FORM I-1 (Continued)

8. Which of the following things, if any, would you personally like the Drug/Alcohol Education Program on this post to cover? (Check as many as apply)

1. The Army's rules and regulations about using alcohol and drugs (15)
 2. What alcohol and drugs will do to my mind or body
 3. The dangers of excessive drinking and drug use
 4. How to handle drug/alcohol-related emergencies (bad trips, getting strung out)
 5. Where to get help in getting off alcohol or drugs
 6. How not to get hepatitis from a hypodermic needle
 7. An understanding of some of the reasons why people drink too much or use drugs
 8. My feelings about myself and what I want to do with my life, and what this implies for whether I should drink too much or use drugs
 9. How much alcohol or drugs I can use safely
1. Which drugs are most dangerous (16)
 2. How not to get caught taking drugs/drinking too much
 3. Ways other than alcohol or drugs I can get kicks or fun out of life
 4. How to get along better with others
 5. Nothing at all
 6. The exemption policy
 7. Don't know
 8. Other (please explain): _____

FORM I-1 (Continued)

9. Which, if any, of the following messages about drugs and alcohol did the Drug/Alcohol Education Program try to get across? (Check as many as apply for each column)

	<u>Drugs</u>	<u>Alcohol</u>
1. Don't know--never attended drug/alcohol education at this post	____ 1. (17)	____ 1. (18)
2. Don't use at all	____ 2.	____ 2.
3. Don't use on duty	____ 3.	____ 3.
4. A little use is OK	____ 4.	____ 4.
5. If you use, use safely	____ 5.	____ 5.
6. The decision to use is your own. The Army will help you understand yourself better, so you can make that decision	____ 6.	____ 6.
7. Here are the facts; you make up your own mind	____ 7.	____ 7.
8. Get your kicks from something else	____ 8.	____ 8.
9. You will be punished if you're caught	____ 9.	____ 9.
0. Side-effects are hell	____ 0.	____ 0.
X. The Army will help you get off drugs or alcohol if you want to	____ X.	____ X.
Y. Other (specify) _____	____ Y.	____ Y.

FORM I-1 (Continued)

10. Which, if any, of the messages you checked in Q.9 above did you believe? (Check as many as apply for each column)

	<u>Drugs</u>	<u>Alcohol</u>
1. Don't know--never attended drug/ alcohol education at this post	____ 1. (19)	____ 1. (21)
2. Don't use at all	____ 2.	____ 2.
3. Don't use on duty	____ 3.	____ 3.
4. A little use is OK	____ 4.	____ 4.
5. If you use, use safely	____ 5.	____ 5.
6. The decision to use is your own. The Army will help you understand yourself better, so you can make that decision	____ 6.	____ 6.
7. Here are the facts; you make up your own mind	____ 7.	____ 7.
8. Get your kicks from something else	____ 8.	____ 8.
9. You will be punished if you're caught	____ 9.	____ 9.
0. Side-effects are hell	____ 0.	____ 0.
1. The Army will help you get off drugs or alcohol if you want to	____ 1. (20)	____ 1. (22)
2. Other (specify) _____	____ 2.	____ 2.
3. Didn't believe any of it	____ 3.	____ 3.

FORM I-1 (Continued)

11. In which of the following areas, if any, did you learn a lot from drug/alcohol education at this post? (Check as many as apply)

0. Doesn't apply--I never received drug/alcohol education at this post (23)
1. The Army's rules and regulations about using alcohol and drugs
2. What alcohol and drugs will do to my mind/body
3. The dangers of excessive drinking and drug use
4. How to handle drug/alcohol-related emergencies (bad trips, getting strung out)
5. Where to get help in getting off drugs or alcohol
6. How not to get hepatitis from a hypodermic needle
7. An understanding of some of the reasons why people use drugs/alcohol
8. My feelings about myself and what I want to do with my life and what this implies for whether I should use drugs or abuse alcohol
9. How much alcohol/drugs I can use safely
1. Which drugs are most dangerous (24)
2. How not to get caught
3. Ways other than drugs/alcohol I can get kicks or fun out of life
4. How to get along better with others
5. I didn't learn a lot about anything
6. The exemption policy
7. Other (specify) _____

FORM I-1 (Continued)

12. What, if anything, was good about drug/alcohol education at this post? (Check as many as apply)

1. Doesn't apply--I never received drug/alcohol education at this post
2. Instructors knew what they were talking about; they were accurate
3. It was real, the truth
4. It was balanced
5. It was powerful, strong; it scared me; it was an effective presentation; it made me think
6. Confirmed my own or other's experience
7. It was open-minded
8. Suggested alternatives to drugs or alcohol
9. Nothing
9. Other (specify) _____

(25)

FORM I-1 (Continued)

13. What, if anything, was bad about drug/alcohol education at this post?

(Check as many as apply)

1. Doesn't apply - never received drug/alcohol education at this post. (26)
2. They didn't know what they were talking about; they were inaccurate.
3. It was not real; it was propaganda.
4. It was one-sided.
5. It was too dull, bland, ineffective.
6. It was contrary to my own or other's experience.
7. It wasn't strong enough to overcome peer pressure from my friends to use drugs/alcohol.
8. It couldn't break my habit.
9. It didn't change my mind.
0. Nothing.
- X. Other (specify) _____

FORM I-1 (Continued)

14. Which, if any, of the following things were ever mentioned as possible alternatives to drugs/alcohol--things a person could do instead of using drugs or abusing alcohol--in drug/alcohol education you received at this post? (Check as many as apply)
1. Doesn't apply - never received drug/alcohol education at this post (27)
 2. Religion
 3. Hobbies
 4. Sports
 5. Recreation, other than hobbies or sports
 6. Meditation
 7. Yoga
 8. Work
 9. Other (specify) _____
 0. Nothing ever mentioned as an alternative to drugs or alcohol
15. Which, if any, of the things listed below are you doing more than before they were mentioned in drug/alcohol education? (Check as many as apply)
1. Doesn't apply - never received drug/alcohol education at this post (28)
 2. Religion
 3. Hobbies
 4. Sports
 5. Recreation, other than hobbies or sports
 6. Meditation
 7. Yoga
 8. Work
 9. Other (specify) _____
 0. None of the above

FORM I-1 (Continued)

16. Do you feel that drug and alcohol education at this post is effective in getting people to stop using drugs or drinking too much, or not? (Check one for each column)

	<u>Drugs</u>	<u>Drinking too much</u>
1. Yes	____ 1. (29)	____ 1. (30)
2. No	____ 2.	____ 2.
3. Don't know	____ 3.	____ 3.

17. Do you personally know of anyone at this post who stopped using drugs or drinking too much at least partly because of drug/alcohol education, or not? (Check one for each column)

	<u>Drugs</u>	<u>Drinking too much</u>
1. Yes	____ 1. (31)	____ 1. (32)
2. No	____ 2.	____ 2.
3. Don't know	____ 3.	____ 3.

18. Do you think that drug/alcohol education at this post is effective in keeping people from starting to use drugs/drink too heavily, or not? (Check one for each column)

	<u>Drugs</u>	<u>Drinking too much</u>
1. Yes	____ 1. (33)	____ 1. (34)
2. No	____ 2.	____ 2.
3. Don't know	____ 3.	____ 3.

19. Do you personally know of anyone at this post who has decided not to start using drugs or drinking too heavily at least partly due to drug/alcohol education, or not? (Check one for each column)

	<u>Drugs</u>	<u>Drinking too much</u>
1. Yes	____ 1. (35)	____ 1. (36)
2. No	____ 2.	____ 2.
3. Don't know	____ 3.	____ 3.

FORM I-1 (Continued)

20. What effects, if any, has drug/alcohol education at this post had on your using drugs? (Check as many as apply)

- 1. Doesn't apply - never had drug/alcohol education at this post (37)
- 2. No effect
- 3. Got me to stay off drugs
- 4. Got me to stop using drugs
- 5. Got me to cut down use of drugs
- 6. Got me to switch from hard to soft drugs
- 7. Got me to start drugs
- 8. Got me to restart drugs
- 9. Got me to increase my use of drugs
- 0. Got me to switch from soft to hard drugs

21. What effects, if any, has drug/alcohol education at this post had on your use of alcohol? (Check as many as apply)

- 1. Doesn't apply - never had drug/alcohol education at this post (38)
- 2. No effect
- 3. Got me to stay off alcohol
- 4. Got me to stop using alcohol
- 5. Got me to cut down use of alcohol
- 6. Got me to start alcohol
- 7. Got me to restart alcohol
- 8. Got me to increase my use of alcohol

FORM I-1 (Continued)

Below are some statements some people have made about drugs and alcohol.

For each one, please check whether you agree strongly, agree somewhat, disagree somewhat, disagree strongly, or have no opinion.

	<u>Agree Strongly</u>	<u>Agree Somewhat</u>	<u>Disagree Somewhat</u>	<u>Disagree Strongly</u>	<u>No Opinion</u>
1. Education is a good way of preventing drug use.	— 1.	— 2.	— 3.	— 4.	— 5. (39)
2. Today, drug use is an equally big problem among the children of wealthy, middle-income, and poor families.	— 1.	— 2.	— 3.	— 4.	— 5. (40)
3. Most people who smoke marijuana use it for a while and then go to something stronger.	— 1.	— 2.	— 3.	— 4.	— 5. (41)
4. People who drink more than they should are the old and the poor.	— 1.	— 2.	— 3.	— 4.	— 5. (42)
5. The best way to prevent drug use is to make detection measures more effective.	— 1.	— 2.	— 3.	— 4.	— 5. (43)
6. Education is a good way of keeping people from drinking too much.	— 1.	— 2.	— 3.	— 4.	— 5. (44)
7. Laws against drug use are based on facts.	— 1.	— 2.	— 3.	— 4.	— 5. (45)
8. People who work toward goals that will benefit others seldom use drugs.	— 1.	— 2.	— 3.	— 4.	— 5. (46)
9. Using marijuana is less harmful than drinking too much.	— 1.	— 2.	— 3.	— 4.	— 5. (47)
10. More severe laws will deter use of drugs.	— 1.	— 2.	— 3.	— 4.	— 5. (48)
11. Only emotionally disturbed people take drugs when they know the dangers.	— 1.	— 2.	— 3.	— 4.	— 5. (49)

FORM I-1 (Continued)

	<u>Agree Strongly</u>	<u>Agree Somewhat</u>	<u>Disagree Somewhat</u>	<u>Disagree Strongly</u>	<u>No Opinion</u>
12. The laws should treat marijuana and "soft drugs" differently from heroin and other "hard drugs."	— 1.	— 2.	— 3.	— 4.	— 5. (50)
13. The best way to deal with someone who drinks too much is to transfer him to another unit.	— 1.	— 2.	— 3.	— 4.	— 5. (51)
14. First drug offenders on this post usually get off with too little punishment.	— 1.	— 2.	— 3.	— 4.	— 5. (52)
15. Stiff law enforcement decreases criminal behavior associated with drug use.	— 1.	— 2.	— 3.	— 4.	— 5. (53)
16. People who drink too much are sick.	— 1.	— 2.	— 3.	— 4.	— 5. (54)
17. A lot of people need drugs to cope with stress.	— 1.	— 2.	— 3.	— 4.	— 5. (55)
18. People use drugs as an escape.	— 1.	— 2.	— 3.	— 4.	— 5. (56)
19. Diet pills are as dangerous as heroin.	— 1.	— 2.	— 3.	— 4.	— 5. (57)
20. If a user turns himself in he should be given much support by his unit's leadership.	— 1.	— 2.	— 3.	— 4.	— 5. (58)
21. The Department of the Army is too lenient with marijuana users.	— 1.	— 2.	— 3.	— 4.	— 5. (59)
22. The Department of the Army is too lenient with heroin and cocaine users.	— 1.	— 2.	— 3.	— 4.	— 5. (60)
23. Drug addicts should be treated as sick people and not as criminals.	— 1.	— 2.	— 3.	— 4.	— 5. (61)

Please answer the following questions to the best of your ability and knowledge. This is not to test your personal knowledge, but will be used to evaluate Army Alcohol and Drug Education Programs in terms of groups, not individuals. The first part consists of standard multiple choice items, and the second part consists of true-false items. Please check what you think is the best answer for each item.*

Questions 1-5 concern "tolerance" and "physical dependence." When a drug is repeatedly used and the user requires successively higher doses for the same effect, he is said to develop tolerance. When a drug is suddenly stopped (withdrawn) after continued use, the occurrence of withdrawal signs such as cramps, nausea, sweating, nasal congestion, or convulsions is evidence of physical dependence on the drug.

1. Repeated use of barbiturates has been found to cause: (Check one)

- 1. Tolerance but not physical dependence (62)
- 2. Physical dependence but not tolerance
- 3. Both tolerance and physical dependence
- 4. Neither tolerance nor physical dependence

2. Repeated use of LSD has been found to cause: (Check one)

- 1. Tolerance but not physical dependence (63)
- 2. Physical dependence but not tolerance
- 3. Both tolerance and physical dependence
- 4. Neither tolerance nor physical dependence

*On this sample form, the correct responses have been checked for the reader's information.

FORM I-1 (Continued)

3. Repeated use of heroin has been found to cause: (Check one)

- 1. Tolerance but not physical dependence (64)
- 2. Physical dependence but not tolerance
- 3. Both tolerance and physical dependence
- 4. Neither tolerance nor physical dependence

4. Physical dependence is most serious with which of the following? (Check one)

- 1. Amphetamines (65)
- 2. LSD
- 3. Cocaine
- 4. Barbiturates
- 5. Hashish

5. Tolerance develops least rapidly to which of the following? (Check one)

- 1. Dexamphetamine (66)
- 2. Methamphetamine
- 3. LSD
- 4. Secobarbital
- 5. Hashish

FORM I-1 (Continued)

On Questions 6-21, mark the letter indicating which of the following drugs best fits the description.

S = Secobarbital Sodium (Seconal)

H = Heroin

A = Amphetamine or Methamphetamine

C = Cocaine

L = LSD

M = Marijuana

6. Four hours after swallowing three or four tablets of this drug, the user may go on a work spree--polishing equipment, tidying work space, etc. (Check one)

1. S 3. A 5. L (67)
 2. H 4. C 6. M

7. Shortly after swallowing some of these capsules, the user may begin to slur speech and stagger as if drunk. (Check one)

1. S 3. A 5. L (68)
 2. H 4. C 6. M

8. Sniffing some of this powder results in greater self confidence and energy. (Check one)

1. S 3. A 5. L (69)
 2. H 4. C 6. M

FORM I-1 (Continued)

9. Stopping this drug after a week of steady use may cause something resembling a bad head cold or a case of the flu. (Check one)

1. S 3. A 5. L (70)
 2. H 4. C 6. M

10. This drug is often injected repeatedly at two-hour intervals for several days in a row and then voluntarily stopped for days or longer. (Check one)

1. S 3. A 5. L (71)
 2. H 4. C 6. M

11. Stopping this drug after a two-day spree often results in sleepiness and hunger. (Check one)

1. S 3. A 5. L (72)
 2. H 4. C 6. M

12. Stopping this drug after continued use of high doses is likely to result in convulsions that may be fatal. (Check one)

1. S 3. A 5. L (73)
 2. H 4. C 6. M

13. Is commonly prescribed to help people sleep. (Check one)

1. S 3. A 5. L (74)
 2. H 4. C 6. M

FORM I-1 (Continued)

14. Is often prescribed to help control appetite in overweight persons. (Check one)

1. S 3. A 5. L (75)
 2. H 4. C 6. M

15. Stopping this drug after a week of continuous use is likely to cause enlargement of pupils and fits of yawning. (Check one)

1. S 3. A 5. L (76)
 2. H 4. C 6. M

16. One tablet of this drug will help some sleepy persons to stay awake. (Check one)

1. S 3. A 5. L (??)
 2. H 4. C 6. M

17. Very small doses may cause hallucinations. (Check one)

1. S 3. A 5. L (78)
 2. H 4. C 6. M

End of Card 1 1
(80)

Questionnaire No. 1 2 3 4

18. Is classed as a "stimulant" but is never prescribed for this purpose by American physicians. (Check one)

1. S 3. A 5. L (5)
 2. H 4. C 6. M

FORM I-1 (Continued)

19. Is very similar to morphine. (Check one)

1. S 3. A 5. L (6)
 2. H 4. C 6. M

20. Is often smoked at frequent intervals, but medical authorities do not believe this leads to physical dependence. (Check one)

1. S 3. A 5. L (7)
 2. H 4. C 6. M

21. Is believed to cause "flashbacks," during which the effects of the drug are experienced even though the drug has not been taken for weeks. (Check one)

1. S 3. A 5. L (8)
 2. H 4. C 6. M

22. Methaqualone (Quaalude, Sopors, Mandrax) is most similar to which of the following. (Check one)

1. Amphetamines (9)
 2. Morphine
 3. Cocaine
 4. LSD
 5. Barbiturates

FORM I-1 (Continued)

23. Mescaline (mescal, peyote) is most similar to which of the following? (Check one)

- 1. Amphetamines (10)
- 2. Morphine
- 3. Cocaine
- 4. LSD
- 5. Barbiturates

24. Which of the following is true about heroin? (Check one)

- 1. Soon after injection, the user is likely to become egotistical and aggressive (11)
- 2. It dilates the pupils
- 3. "Street users" often die suddenly after injection
- 4. It increases sexual drive
- 5. It is used by U.S. Army physicians to ease pain in the wounded

25. The saying, "Speed kills," is best related to which of the following? (Check one)

- 1. Sudden deaths from acute overdosage (12)
- 2. Overexertion by athletes using drugs to improve performance
- 3. Long-term liver damage
- 4. Fatal convulsions following abrupt withdrawal of the drug
- 5. Fatal respiratory depression when the drug is combined with alcohol

FORM I-1 (Continued)

26. Which of the following is most dangerous to life when taken with alcohol? (Check one)

- 1. Amphetamine (13)
- 2. Cocaine
- 3. Aspirin
- 4. Secobarbital
- 5. Hashish

27. Which is the best explanation for the close relationship between heroin use and crime? (Check one)

- 1. A typical heroin habit is very expensive (14)
- 2. Heroin actively inspires criminal behavior
- 3. The narcotic effect of heroin dulls the moral sense
- 4. Heroin users often run afoul of the law accidentally when in a state of intoxication
- 5. All of the above are important causes

28. Which of the following statements best describes the relationship of drug use to mental illness? (Check one)

- 1. Its use can cause mental illness (15)
- 2. Its use is not related to mental illness
- 3. Its use may reveal mental illness or make mental illness worse

29. Which one of the following is the most likely description of a person who has taken more than a prescribed amount of opiate? *(Check one)*

- 1. Excited and hyperactive
- 2. Hostile and aggressive
- 3. Nervous and fearful
- 4. Quiet and inactive
- 5. None of the above

(16)

30. When taken more often than prescribed or in larger doses than directed, some cough medicines may cause addiction because they contain: *(Check one)*

- 1. Heroin
- 2. Codeine
- 3. Morphine
- 4. Phenobarbital
- 5. Both 2 and 3

(17)

31. Which of the following are the most probable effects of cocaine?
(Check one)

- 1. Daydreaming, enlarged pupils, habit-formation
- 2. Inactivity, small pupils, addiction
- 3. Slurred speech, poor balance
- 4. Excessive talking, excitement, habit-formation
- 5. None of the above

(18)

FORM I-1 (Continued)

32. The effects of cocaine are those of a: (Check one)

1. Stimulant (19)
 2. Depressant
 3. Narcotic

33. Studies concerning the possibility of physical damage from marijuana indicate that: (Check one)

1. Its use does damage to nerves and lungs (20)
 2. Its use does no physical damage
 3. It has not been proved to be physically harmful
 4. It is physically harmful only if often used

34. Which is the most likely description of a person who has taken more than a prescribed dose of an amphetamine? (Check one)

1. Giggling, daydreaming (21)
 2. Inactive, quiet, small pupils
 3. Poor balance, slurred speech, short temper
 4. Restless, perspiring

35. Dependence on barbiturates includes: (Check one)

1. Psychological dependence (22)
 2. Physical dependence
 3. The possibility of convulsions and death during withdrawal
 4. All of the above
 5. Only 1 and 2 of the above

FORM I-1 (Continued)

36. A 160-pound man begins drinking beer at 1600, finishing two quarts of American beer by 1800 without having eaten. About what time will his blood alcohol concentration fall below 0.01% (the essentially "sober" level)? (Check one)

1. 2000 (23)
 2. 2300
 3. 0200
 4. 0400

37. Most of the alcohol consumed in a drinking bout is eventually removed by way of: (Check one)

1. Breath (24)
 2. Urine
 3. Conversion to fatty tissue
 4. Metabolism
 5. None of the above

38. The "blackouts" experienced by some very heavy drinkers are periods during which they: (Check one)

1. Lose memory for what happened while intoxicated (25)
 2. Lose consciousness suddenly after only a few drinks
 3. Suffer temporary blindness
 4. Suffer an unusual form of hangover

39. Which of the following accurately describes the results of treatment for alcoholism in the United States? (Check one)

1. Most alcoholics become permanently abstinent (26)
 after treatment
 2. Most alcoholics become normal social drinkers after treatment
 3. Most alcoholics are not benefited by treatment
✓ 4. None of the above

40. Which of the following best fits the known facts about drinking and driving? (Check one)

- ✓ 1. Alcohol is a direct cause of a large proportion of (27)
 traffic deaths
 2. Randomly tested drivers are nearly as likely to have been drinking as are fatally injured drivers
 3. Habitual heavy drinkers are nearly as dangerous sober as drunk
 4. Drivers involved in minor collisions are more likely to have been drinking than those involved in severe crashes

FORM I-1 (Continued)

Check whether each of the following statements is true (T) or False (F).

T(1) F(2)

- 1. Withdrawal of coffee after prolonged heavy use may cause headaches. (28)
- 2. Someone physically dependent on heroin is likely to have fatal convulsions if forced to stop suddenly. (29)
- 3. Someone physically dependent on alcohol is likely to have fatal convulsions if forced to stop suddenly. (30)
- 4. Marijuana in high doses produces effects that are rather similar to those of cocaine. (31)
- 5. Very large amounts of marijuana can be eaten with little or no effect. (32)
- 6. Frequent smoking of heroin is likely to cause physical dependence. (33)
- 7. Alcoholics have a high risk of liver damage. (34)
- 8. The "half-drunk" driver is a greater danger to himself and others than the completely drunk driver. (35)
- 9. A heroin user who has suffered the discomforts of withdrawal is likely to get "hooked" again if the drug is available. (36)
- 10. When taken by mouth, the effects of dexamphetamine and methamphetamine are highly similar. (37)
- 11. Sellers of illegal drugs seldom attempt to "push" them on non-users. (38)
- 12. Delirium tremens (DT's) from alcohol are very uncomfortable but are not a threat to life. (39)

FORM I-1 (Continued)

T(1) F(2)

13. After a full meal, nearly twice as much alcohol is required to reach the same blood concentration as would be obtained on an empty stomach. (40)
14. An experienced drinker can drive as well after a few drinks as when he is sober. (41)
15. Two or three drinks have less effect on the driving of heavy drinkers than they have on the driving of light drinkers. (42)
16. Sufficiently vigorous exercise can double the rate at which alcohol is removed from the body. (43)
17. Frequent users of marijuana seldom drink alcoholic beverages. (44)
18. Alcohol is highly effective in relieving the withdrawal discomfort from heroin. (45)
19. Drinking straight whiskey is more hazardous to the health than drinking whiskey with soda water. (46)
20. There is little to be gained by persuading "problem drinkers" to stop getting drunk, since their real problems are psychological. (47)
21. The blood alcohol level at which someone is legally presumed "intoxicated" for driving purposes is about the same in all countries. (48)
22. Death from morphine overdosage is usually due to respiratory depression. (49)
23. Death in human beings using LSD usually has been the result of suicide or accident. (50)

FORM I-1 (Continued)

The next set of questions is about your own personal use of alcohol and drugs. First, we will give you a few definitions of terms.

Marijuana/hash.....Pot, grass, hash, etc.

Hallucinogens.....LSD, Mescaline, peyote, STP, DOM,
THC, Sernyl, PCP, etc.

Amphetamines.....Benzedrine, Methedrine, Ritalin, speed,
Dexedrine, crystal, etc.

Cocaine.....C, coke, dust, snow

Other uppers.....Preludin, any stimulant other than
cocaine and amphetamines

Barbiturates.....Seconal, Nembutal, Amytal, "reds,"
"yellows," etc.

Other downers.....Doriden, Mandrax, Quaalude, Sopors,
etc.

Darvon.....Darvon

Methadone.....Dollies, dolls

Other Opiates.....Heroin, morphine, opium, Demerol, codeine

FORM I-1 (Continued)

1. For each substance (item) below, please check whether or not you have ever used (or done) it. (Check one for each line)

	<u>Have used/done it</u>	<u>Have never used/done it</u>
Drinking too heavily	— 1.	— 2. (51)
Marijuana/hash	— 1.	— 2. (52)
Hallucinogens	— 1.	— 2. (53)
Amphetamines	— 1.	— 2. (54)
Cocaine	— 1.	— 2. (55)
Other uppers	— 1.	— 2. (56)
Barbiturates	— 1.	— 2. (57)
Other downers	— 1.	— 2. (58)
Darvon	— 1.	— 2. (59)
Methadone	— 1.	— 2. (60)
Other opiates	— 1.	— 2. (61)

2. For each substance (item) below, please check whether or not you ever used (or did) it before entering the Army. (Check one for each line)

	<u>Used/did it before entering Army</u>	<u>Never used/did before entering Army</u>
Drinking too heavily	— 1.	— 2. (62)
Marijuana/hash	— 1.	— 2. (63)
Hallucinogens	— 1.	— 2. (64)
Amphetamines	— 1.	— 2. (65)
Cocaine	— 1.	— 2. (66)
Other uppers	— 1.	— 2. (67)
Barbiturates	— 1.	— 2. (68)
Other downers	— 1.	— 2. (69)
Darvon	— 1.	— 2. (70)
Methadone	— 1.	— 2. (71)
Other opiates	— 1.	— 2. (72)

End of Card 2 2
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Questionnaire No. — 1 2 3 4

FORM I-1 (Continued)

3. For each substance (item) below, please check whether or not you have used (done) it at this post. (Check one for each line)

	<u>Used/did it at this post</u>	<u>Never used/did it at this post</u>	
Drinking too heavily	____ 1.	____ 2.	(5)
Marijuana/hash	____ 1.	____ 2.	(6)
Hallucinogens	____ 1.	____ 2.	(7)
Amphetamines	____ 1.	____ 2.	(8)
Cocaine	____ 1.	____ 2.	(9)
Other uppers	____ 1.	____ 2.	(10)
Barbiturates	____ 1.	____ 2.	(11)
Other downers	____ 1.	____ 2.	(12)
Darvon	____ 1.	____ 2.	(13)
Methadone	____ 1.	____ 2.	(14)
Other opiates	____ 1.	____ 2.	(15)

FORM I-1 (Continued)

4. Since you came to this post, would you say your use of these drugs/ too heavy drinking has started (I didn't do it before, but I do now); increased (I do it more now); stayed the same (I do it the same as before); stayed zero (I didn't do it before and don't do it now); decreased (I do it less now); or stopped (I did it before but don't now)? (Please make one check for each line)

	<u>Started</u>	<u>Increased</u>	<u>Stayed Same</u>	<u>Stayed Zero</u>	<u>Decreased</u>	<u>Stopped</u>
Drinking too heavily	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u> (16)
Marijuana/hash	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u> (17)
Hallucinogens	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u> (18)
Amphetamines	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u> (19)
Cocaine	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u> (20)
Other uppers	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u> (21)
Barbiturates	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u> (22)
Other downers	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u> (23)
Darvon	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u> (24)
Methadone	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u> (25)
Other opiates	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u> (26)

FORM I-1 (Continued)

5. On how many days during the last 30 days did you use (or do) each of the following? (For instance, if you used marijuana/hash 6 days, make a check mark under the column headed "3-6 days." Fill out one line at a time. Check once for each line.)

	<u>None</u>	<u>1-2 Days</u>	<u>3-6 Days</u>	<u>7-14 Days</u>	<u>15-29 Days</u>	<u>30 Days</u>	
Drink too heavily	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(27)
Marijuana/Hash	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(28)
Hallucinogens	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(29)
Amphetamines	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(30)
Cocaine	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(31)
Other Uppers	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(32)
Barbiturates	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(33)
Other Downers	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(34)
Darvon	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(35)
Mathadone	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(36)
Other Opiates	<u>1.</u>	<u>2.</u>	<u>3.</u>	<u>4.</u>	<u>5.</u>	<u>6.</u>	(37)

This last section asks about your background.

1. Are you male or female? (Please check one)

1. Male 2. Female (38)

2. How old were you on your last birthday (Please check one)

1. 18 or less 3. 21-22 5. 26-29 (39)
2. 19-20 4. 23-25 6. 30 or older

FORM I-1 (Continued)

3. Which one of the following do you consider yourself
(Please check one)

- 1. Spanish/Mexican American
- 2. White (other than Spanish/Mexican American)
- 3. Black
- 4. Other (Oriental, American Indian, etc.)

(40)

4. What is your marital status? *(Please check one)*

- 1. Married
- 2. Legally Separated
- 3. Divorced
- 4. Widowed
- 5. Never married
(single)

(41)

5. What is your highest level of education, including accepted GED credits? *(Please check one)*

- 1. Grammar school
- 2. Some high school
- 3. GED (high school equivalent)
- 4. High school graduate (diploma)
- 5. Post high school trade/technical school (no college)
- 6. 1-3 years college
- 7. 4 years college/degree
- 8. Some graduate work
- 9. Graduate degree
(masters, doctorate)

(42)

6. Where did you live just before going into the Army? *(Please check one)*

- 1. A farm/ranch
- 2. In the country but not a farm/ranch
- 3. Town/small city (less than 25,000 people then)
- 4. Medium city (25,000-100,000 people then)
- 5. Large city (over 100,000 people then)
- 6. Suburb of a large city
- 7. Suburb of a small/medium city

(43)

FORM I-1 (Continued)

7. What is your present military pay grade? (Please check one)

- | | | | |
|---------------------------------|---------------------------------|---------------------------------|------|
| <input type="checkbox"/> 1. E-1 | <input type="checkbox"/> 4. E-4 | <input type="checkbox"/> 7. E-7 | (44) |
| <input type="checkbox"/> 2. E-2 | <input type="checkbox"/> 5. E-5 | <input type="checkbox"/> 8. E-8 | |
| <input type="checkbox"/> 3. E-3 | <input type="checkbox"/> 6. E-6 | <input type="checkbox"/> 9. E-9 | |

8. What is your present Army status? (Please check one)

- | | | |
|--|---------------------------------------|------|
| <input type="checkbox"/> 1. Regular Army | <input type="checkbox"/> 2. Reservist | (45) |
|--|---------------------------------------|------|

9. What kind of a unit (company) are you in? (Please check one)

- | | |
|---|------|
| <input type="checkbox"/> 1. Combat Arms [for example, Infantry, Airborne, Field Artillery, Air Defense Artillery, Armor, Cavalry, Special Forces Engineering Units designated as combat arm units] | (46) |
| <input type="checkbox"/> 2. Combat Support Arms [for example, Signal Corps, Military Police, Aviation, Chemical Corps. Transportation (Direct Support), Ordnance, Engineers not designated as combat arm units] | |
| <input type="checkbox"/> 3. Combat Service Support Arms [for example, Quartermaster, Judge Advocate General, Finance, Medical, Dental, Adjutant General, Military Intelligence, Chaplain, Women's Army Corps, Transportation (General Support)] | |

10. Do you live on or off this post? (Please check one)

- | | | |
|---|--|------|
| <input type="checkbox"/> 1. On the post | <input type="checkbox"/> 2. Off the post | (47) |
|---|--|------|

FORM I-1 (Continued)

11. How long have you been assigned to this post? (Please check one)

- | | | |
|--|---|------|
| <input type="checkbox"/> 1. Less than 6 months | <input type="checkbox"/> 4. Over 2 years to 3 years | (48) |
| <input type="checkbox"/> 2. 6-12 months | <input type="checkbox"/> 5. Over 3 years to 4 years | |
| <input type="checkbox"/> 3. Over 1 year to 2 years | <input type="checkbox"/> 6. Over 4 years | |

12. How long have you been in the Army? (Please check one)

- | | | |
|---|---|------|
| <input type="checkbox"/> 1. Less than 6 months | <input type="checkbox"/> 6. 5-8 years | (49) |
| <input type="checkbox"/> 2. 6-12 months | <input type="checkbox"/> 7. 9-12 years | |
| <input type="checkbox"/> 3. Over 1 year to 2 years | <input type="checkbox"/> 8. 13-20 years | |
| <input type="checkbox"/> 4. Over 2 years to 3 years | <input type="checkbox"/> 9. Over 20 years | |
| <input type="checkbox"/> 5. Over 3 years to 4 years | | |

13. Do you plan on making the Army your career or not? (Please check one)

- | | | | |
|---------------------------------|--------------------------------|--|------|
| <input type="checkbox"/> 1. Yes | <input type="checkbox"/> 2. No | <input type="checkbox"/> 3. Don't know | (50) |
|---------------------------------|--------------------------------|--|------|

End of Card 3

3
(80)

Thank you for your help. If you have any other comments, please write them below.

FORM I-2

A SAMPLE QUESTIONNAIRE FOR PRE- AND POST- SURVEYS OF LEADERS: KEYPUNCH VERSION
DRUG AND ALCOHOL SURVEY

WHAT THIS IS ABOUT

This survey consists of questions about alcohol, drugs, and leadership. The survey is being given to members of this post's leadership structure as part of an evaluation of Army education programs. Please indicate the answer or answers to each question that come(s) closest to your own beliefs, feelings, or views. DO NOT WRITE YOUR NAME OR SOCIAL SECURITY NUMBER.

Questionnaire No. (1) (2) (3) (4)

In responding to the following statements, please check the response that best expresses your feeling about the question.

1. Would you say you are very well informed, somewhat informed, somewhat uninformed, or very uninformed about drugs and alcohol, their use, and their users? (Check one)

1. Very well informed 3. Somewhat uninformed (5)
 2. Somewhat informed 4. Very uninformed

2. At present, to what extent do you feel you can deal effectively with individuals who may come to your attention as a result of the use of drugs? (Check one) (6)

1. Can deal very effectively 3. Can deal somewhat ineffectively
 2. Can deal somewhat effectively 4. Cannot deal at all effectively

FORM I-2 (Continued)

3. At present, to what extent do you feel you can deal effectively with individuals who may come to your attention as a result of the excessive use of alcohol? (Check one) (7)
1. Can deal very effectively 3. Can deal somewhat ineffectively
 2. Can deal somewhat effectively 4. Cannot deal at all effectively
4. At present, how serious do you believe drug use to be at this post? (Check one) (8)
1. Very serious 4. Not at all serious
 2. Somewhat serious 5. Don't know
 3. Not very serious
5. How serious do you believe problem drinking to be at this post? (Check one) (9)
1. Very serious 4. Not at all serious
 2. Somewhat serious 5. Don't know
 3. Not very serious
6. How sure are you of your knowledge about drugs and your understanding of the drug problem? (Check one) (10)
1. Very sure 3. Somewhat unsure
 2. Somewhat sure 4. Not at all sure
7. How sure are you of your knowledge about alcohol and your understanding of the alcohol problem? (Check one) (11)
1. Very sure 3. Somewhat unsure
 2. Somewhat sure 4. Not at all sure

FORM I-2 (Continued)

8. How confident are you that you would be able to recognize that someone in your unit is addicted to heroin? (Check one)

1. Very confident 3. Not very confident (12)
 2. Somewhat confident 4. Not at all confident

9. How confident are you that you would be able to recognize that someone in your unit is using amphetamines? (Check one)

1. Very confident 3. Not very confident (13)
 2. Somewhat confident 4. Not at all confident

10. How confident are you that you would be able to recognize that someone in your unit is using barbiturates? (Check one)

1. Very confident 3. Not very confident (14)
 2. Somewhat confident 4. Not at all confident

11. How confident are you that you would be able to recognize that someone in your unit is using marijuana? (Check one)

1. Very confident 3. Not very confident (15)
 2. Somewhat confident 4. Not at all confident

12. How confident are you that you would be able to recognize that someone in your unit is drinking excessively? (Check one)

1. Very confident 3. Not very confident (16)
 2. Somewhat confident 4. Not at all confident

FORM I-2 (Continued)

Below are some statements some people have made about drugs and alcohol.
 For each one, please check whether you agree strongly, agree somewhat, disagree somewhat, disagree strongly, or have no opinion.

	<u>Agree Strongly</u>	<u>Agree Somewhat</u>	<u>Disagree Somewhat</u>	<u>Disagree Strongly</u>	<u>No Opinion</u>
1. Education is a good way of preventing drug use.	— 1.	— 2.	— 3.	— 4.	— 5. (17)
2. Today drug use is an equally big problem among the children of wealthy, middle-income, and poor families.	— 1.	— 2.	— 3.	— 4.	— 5. (18)
3. Most people who smoke marijuana use it for a while and then go to something stronger.	— 1.	— 2.	— 3.	— 4.	— 5. (19)
4. People who drink more than they should are the old and the poor.	— 1.	— 2.	— 3.	— 4.	— 5. (20)
5. The best way to prevent drug use is to make detection measures more effective.	— 1.	— 2.	— 3.	— 4.	— 5. (21)
6. Education is a good way of keeping people from drinking too much.	— 1.	— 2.	— 3.	— 4.	— 5. (22)
7. Laws against drug use are based on facts.	— 1.	— 2.	— 3.	— 4.	— 5. (23)
8. People who work toward goals that will benefit others seldom use drugs.	— 1.	— 2.	— 3.	— 4.	— 5. (24)
9. Using marijuana is less harmful than drinking too much.	— 1.	— 2.	— 3.	— 4.	— 5. (25)
10. More severe laws will deter use of drugs.	— 1.	— 2.	— 3.	— 4.	— 5. (26)

FORM I-2 (Continued)

	<u>Agree Strongly</u>	<u>Agree Somewhat</u>	<u>Disagree Somewhat</u>	<u>Disagree Strongly</u>	<u>No Opinion</u>
11. Only emotionally disturbed people take drugs when they know the dangers.	— 1.	— 2.	— 3.	— 4.	— 5. (27)
12. The laws should treat marijuana and "soft drugs" differently from heroin and other "hard drugs."	— 1.	— 2.	— 3.	— 4.	— 5. (28)
13. The best way to deal with someone who drinks too much is to transfer him to another unit.	— 1.	— 2.	— 3.	— 4.	— 5. (29)
14. First drug offenders on this post usually get off with too little punishment.	— 1.	— 2.	— 3.	— 4.	— 5. (30)
15. Stiff law enforcement decreases criminal behavior associated with drug use.	— 1.	— 2.	— 3.	— 4.	— 5. (31)
16. People who drink too much are sick.	— 1.	— 2.	— 3.	— 4.	— 5. (32)
17. A lot of people need drugs to cope with stress.	— 1.	— 2.	— 3.	— 4.	— 5. (33)
18. People use drugs as an escape.	— 1.	— 2.	— 3.	— 4.	— 5. (34)
19. Diet pills are as dangerous as heroin.	— 1.	— 2.	— 3.	— 4.	— 5. (35)
20. If a user turns himself in, he should be given much support by his unit's leadership.	— 1.	— 2.	— 3.	— 4.	— 5. (36)
21. The Department of the Army is too lenient with marijuana users.	— 1.	— 2.	— 3.	— 4.	— 5. (37)
22. The Department of the Army is too lenient with heroin and cocaine users.	— 1.	— 2.	— 3.	— 4.	— 5. (38)
23. Drug addicts should be treated as sick people and not as criminals.	— 1.	— 2.	— 3.	— 4.	— 5. (39)

FORM I-2 (Continued)

Please answer the following questions to the best of your ability and knowledge. This is not to test your personal knowledge, but will be used to evaluate Army Alcohol and Drug Education Programs in terms of groups, not individuals. The first part consists of standard multiple choice items, and the second part consists of true-false items. Please check what you think is the best answer for each item.*

Questions 1-5 concern "tolerance" and "physical dependence." When a drug is repeatedly used and the user requires successively higher doses for the same effect, he is said to develop tolerance. When a drug is suddenly stopped (withdrawn) after continued use, the occurrence of withdrawal signs such as cramps, nausea, sweating, nasal congestion, or convulsions is evidence of physical dependence on the drug.

1. Repeated use of barbiturates has been found to cause: (Check one)

- 1. Tolerance but not physical dependence (40)
- 2. Physical dependence but not tolerance
- 3. Both tolerance and physical dependence
- 4. Neither tolerance nor physical dependence

2. Repeated use of LSD has been found to cause: (Check one)

- 1. Tolerance but not physical dependence (41)
- 2. Physical dependence but not tolerance
- 3. Both tolerance and physical dependence
- 4. Neither tolerance nor physical dependence

*On this sample form, the correct responses have been checked for the reader's information.

FORM I-2 (Continued)

3. Repeated use of heroin has been found to cause: (Check one) (42)
- 1. Tolerance but not physical dependence
 - 2. Physical dependence but not tolerance
 - 3. Both tolerance and physical dependence
 - 4. Neither tolerance nor physical dependence
4. Physical dependence is most serious with which of the following? (Check one) (43)
- 1. Amphetamines
 - 2. LSD
 - 3. Cocaine
 - 4. Barbiturates
 - 5. Hashish
5. Tolerance develops least rapidly to which of the following? (Check one) (44)
- 1. Dexamphetamine
 - 2. Methamphetamine
 - 3. LSD
 - 4. Secobarbital
 - 5. Hashish

FORM I-2 (Continued)

On Questions 6-21, mark the letter indicating which of the following drugs best fits the description.

S = Secobarbital Sodium (Seconal)

H = Heroin

A = Amphetamine or Methamphetamine

C = Cocaine

L = LSD

M = Marijuana

6. Four hours after swallowing three or four tablets of this drug, the user may go on a work spree--polishing equipment, tidying work space, etc. (Check one)

1. S 3. A 5. L (45)
 2. H 4. C 6. M

7. Shortly after swallowing some of these capsules, the user may begin to slur speech and stagger as if drunk. (Check one)

1. S 3. A 5. L (46)
 2. H 4. C 6. M

8. Sniffing some of this powder results in greater self confidence and energy. (Check one)

1. S 3. A 5. L (47)
 2. H 4. C 6. M

FORM I-2 (Continued)

9. Stopping this drug after a week of steady use may cause something resembling a bad head cold or a case of the flu. (Check one)

1. S 3. A 5. L (48)
 2. H 4. C 6. M

10. This drug is often injected repeatedly at two-hour intervals for several days in a row and then voluntarily stopped for days or longer. (Check one)

1. S 3. A 5. L (49)
 2. H 4. C 6. M

11. Stopping this drug after a two-day spree often results in sleepiness and hunger. (Check one)

1. S 3. A 5. L (50)
 2. H 4. C 6. M

12. Stopping this drug after continued use of high doses is likely to result in convulsions that may be fatal. (Check one)

1. S 3. A 5. L (51)
 2. H 4. C 6. M

13. Is commonly prescribed to help people sleep. (Check one)

1. S 3. A 5. L (52)
 2. H 4. C 6. M

FORM I-2 (Continued)

14. Is often prescribed to help control appetite in overweight persons. (Check one)

1. S 3. A 5. L (53)
 2. H 4. C 6. M

15. Stopping this drug after a week of continuous use is likely to cause enlargement of pupils and fits of yawning. (Check one)

1. S 3. A 5. L (54)
 2. H 4. C 6. M

16. One tablet of this drug will help some sleepy persons to stay awake. (Check one)

1. S 3. A 5. L (55)
 2. H 4. C 6. M

17. Very small doses may cause hallucinations. (Check one)

1. S 3. A 5. L (56)
 2. H 4. C 6. M

18. Is classed as a "stimulant" but is never prescribed for this purpose by American physicians. (Check one)

1. S 3. A 5. L (57)
 2. H 4. C 6. M

FORM I-2 (Continued)

19. Is very similar to morphine. (Check one)

- | | | |
|--|-------------------------------|------------------------------------|
| <input type="checkbox"/> 1. S | <input type="checkbox"/> 3. A | <input type="checkbox"/> 5. L (58) |
| <input checked="" type="checkbox"/> 2. H | <input type="checkbox"/> 4. C | <input type="checkbox"/> 6. M |

20. Is often smoked at frequent intervals, but medical authorities do not believe this leads to physical dependence. (Check one)

- | | | |
|-------------------------------|-------------------------------|--|
| <input type="checkbox"/> 1. S | <input type="checkbox"/> 3. A | <input type="checkbox"/> 5. L (59) |
| <input type="checkbox"/> 2. H | <input type="checkbox"/> 4. C | <input checked="" type="checkbox"/> 6. M |

21. Is believed to cause "flashbacks," during which the effects of the drug are experienced even though the drug has not been taken for weeks. (Check one)

- | | | |
|-------------------------------|-------------------------------|---|
| <input type="checkbox"/> 1. S | <input type="checkbox"/> 3. A | <input checked="" type="checkbox"/> 5. L (60) |
| <input type="checkbox"/> 2. H | <input type="checkbox"/> 4. C | <input type="checkbox"/> 6. M |

22. Methaqualone (Quaalude, Sopors, Mandrax) is most similar to which of the following. (Check one)

- | | |
|---|------|
| <input type="checkbox"/> 1. Amphetamines | (61) |
| <input type="checkbox"/> 2. Morphine | |
| <input type="checkbox"/> 3. Cocaine | |
| <input type="checkbox"/> 4. LSD | |
| <input checked="" type="checkbox"/> 5. Barbiturates | |

23. Mescaline (mescal, peyote) is most similar to which of the following? (Check one)

- 1. Amphetamines (62)
- 2. Morphine
- 3. Cocaine
- 4. LSD
- 5. Barbiturates

24. Which of the following is true about heroin? (Check one)

- 1. Soon after injection, the user is likely to become egotistical and aggressive (63)
- 2. It dilates the pupils
- 3. "Street users" often die suddenly after injection
- 4. It increases sexual drive
- 5. It is used by U.S. Army physicians to ease pain in the wounded

25. The saying, "Speed kills," is best related to which of the following? (Check one)

(64)

- 1. Sudden deaths from acute overdosage
- 2. Overexertion by athletes using drugs to improve performance
- 3. Long-term liver damage
- 4. Fatal convulsions following abrupt withdrawal of the drug
- 5. Fatal respiratory depression when the drug is combined with alcohol

FORM I-2 (Continued)

26. Which of the following is most dangerous to life when taken with alcohol? (Check one)

- 1. Amphetamine (65)
- 2. Cocaine
- 3. Aspirin
- 4. Secobarbital
- 5. Hashish

27. Which is the best explanation for the close relationship between heroin use and crime? (Check one)

- 1. A typical heroin habit is very expensive (66)
- 2. Heroin actively inspires criminal behavior
- 3. The narcotic effect of heroin dulls the moral sense
- 4. Heroin users often run afoul of the law accidentally when in a state of intoxication
- 5. All of the above are important causes

28. Which of the following statements best describes the relationship of drug use to mental illness? (Check one)

- 1. Its use can cause mental illness
- 2. Its use is not related to mental illness
- 3. Its use may reveal mental illness or make mental illness worse

FORM I-2 (Continued)

29. Which one of the following is the most likely description of a person who has taken more than a prescribed amount of opiate? (Check one)

- 1. Excited and hyperactive (68)
- 2. Hostile and aggressive
- 3. Nervous and fearful
- 4. Quiet and inactive
- 5. None of the above

30. When taken more often than prescribed or in larger doses than directed, some cough medicines may cause addiction because they contain: (Check one)

- 1. Heroin (69)
- 2. Codeine
- 3. Morphine
- 4. Phenobarbital
- 5. Both 2 and 3

31. Which of the following are the most probable effects of cocaine?
(Check one)

- 1. Daydreaming, enlarged pupils, habit-formation (70)
- 2. Inactivity, small pupils, addiction
- 3. Slurred speech, poor balance
- 4. Excessive talking, excitement, habit-formation
- 5. None of the above

FORM I-2 (Continued)

32. The effects of cocaine are those of a: (Check one)

- 1. Stimulant
- 2. Depressant
- 3. Narcotic

(71)

33. Studies concerning the possibility of physical damage from marijuana indicate that: (Check one)

- 1. Its use does damage to nerves and lungs
- 2. Its use does no physical damage
- 3. It has not been proved to be physically harmful
- 4. It is physically harmful only if often used

(72)

34. Which is the most likely description of a person who has taken more than a prescribed dose of an amphetamine? (Check one)

- 1. Giggling, daydreaming
- 2. Inactive, quiet, small pupils
- 3. Poor balance, slurred speech, short temper
- 4. Restless, perspiring

(73)

35. Dependence on barbiturates includes: (Check one)

- 1. Psychological dependence
- 2. Physical dependence
- 3. The possibility of convulsions and death during withdrawal
- 4. All of the above
- 5. Only 1 and 2 of the above

(74)

FORM I-2 (Continued)

36. A 160-pound man begins drinking beer at 1600, finishing two quarts of American beer by 1800 without having eaten. About what time will his blood alcohol concentration fall below 0.01% (the essentially "sober" level)? (Check one)

- 1. 2000 (75)
- 2. 2300
- 3. 0200
- 4. 0400

37. Most of the alcohol consumed in a drinking bout is eventually removed by way of: (Check one)

- 1. Breath (76)
- 2. Urine
- 3. Conversion to fatty tissue
- 4. Metabolism
- 5. None of the above

38. The "blackouts" experienced by some very heavy drinkers are periods during which they: (Check one)

- 1. Lose memory for what happened while intoxicated (77)
- 2. Lose consciousness suddenly after only a few drinks
- 3. Suffer temporary blindness
- 4. Suffer an unusual form of hangover

End of Card 1 1
(80)

Questionnaire No. (1) (2) (3) (4)

FORM I-2 (Continued)

39. Which of the following accurately describes the results of treatment for alcoholism in the United States? (Check one)

- 1. Most alcoholics become permanently abstinent (5)
after treatment
- 2. Most alcoholics become normal social drinkers after treatment
- 3. Most alcoholics are not benefited by treatment
- 4. None of the above

40. Which of the following best fits the known facts about drinking and driving? (Check one)

- 1. Alcohol is a direct cause of a large proportion of (6)
traffic deaths
- 2. Randomly tested drivers are nearly as likely to have been drinking as are fatally injured drivers
- 3. Habitual heavy drinkers are nearly as dangerous sober as drunk
- 4. Drivers involved in minor collisions are more likely to have been drinking than those involved in severe crashes

Check whether each of the following statements is true (T) or False (F).

T(1) F(2)

- 1. Withdrawal of coffee after prolonged heavy use may cause headaches. (7)
- 2. Someone physically dependent on heroin is likely to have fatal convulsions if forced to stop suddenly. (8)
- 3. Someone physically dependent on alcohol is likely to have fatal convulsions if forced to stop suddenly. (9)
- 4. Marijuana in high doses produces effects that are rather similar to those of cocaine. (10)
- 5. Very large amounts of marijuana can be eaten with little or no effect. (11)
- 6. Frequent smoking of heroin is likely to cause physical dependence. (12)
- 7. Alcoholics have a high risk of liver damage. (13)
- 8. The "half-drunk" driver is a greater danger to himself and others than the completely drunk driver. (14)
- 9. A heroin user who has suffered the discomforts of withdrawal is likely to get "hooked" again if the drug is available. (15)
- 10. When taken by mouth, the effects of dexamphetamine and methamphetamine are highly similar. (16)
- 11. Sellers of illegal drugs seldom attempt to "push" them on non-users. (17)
- 12. Delirium tremens (DT's) from alcohol are very uncomfortable but are not a threat to life. (18)

FORM I-2 (Continued)

T(1) F(2)

13. After a full meal, nearly twice as much alcohol is required to reach the same blood concentration as would be obtained on an empty stomach. (19)
14. An experienced drinker can drive as well after a few drinks as when he is sober. (20)
15. Two or three drinks have less effect on the driving of heavy drinkers than they have on the driving of light drinkers. (21)
16. Sufficiently vigorous exercise can double the rate at which alcohol is removed from the body. (22)
17. Frequent users of marijuana seldom drink alcoholic beverages. (23)
18. Alcohol is highly effective in relieving the withdrawal discomfort from heroin. (24)
19. Drinking straight whiskey is more hazardous to the health than drinking whiskey with soda water. (25)
20. There is little to be gained by persuading "problem drinkers" to stop getting drunk, since their real problems are psychological. (26)
21. The blood alcohol level at which someone is legally presumed "intoxicated" for driving purposes is about the same in all countries. (27)
22. Death from morphine overdosage is usually due to respiratory depression. (28)
23. Death in human beings using LSD usually has been the result of suicide or accident. (29)

FORM I-2 (Continued)

This section is concerned with your own feelings about drug/alcohol training.

1. Considering your responsibilities at this installation, do you feel you need more, the same, or less training that you now have about drugs and alcohol? (Check one)

2. What information about drug use and problem drinking, if any, do you not have that you feel would be useful to you? (Check as many as apply)

1. Nothing (31)

2. Status of drug/alcohol problem in my unit

3. Drug/alcohol use prevalence and type on this post

4. Training update on counseling

5. Training update on education

6. Better, more up-to-date, or clearer policy on alcohol and drugs

7. Reasons underlying drug laws

8. Other (specify) _____

FORM I-2 (Continued)

3. Which of the following methods, if any, would be most effective in improving drug/alcohol education at this post? (Check as many as apply)

- 1. More extensive training (32)
 - 2. More use of discussion groups
 - 3. Greater emphasis on counseling
 - 4. More use of drug abuse specialists
 - 5. More coordination with civilian drug program
 - 6. More use of former drug users/problem drinkers
 - 7. Nothing--no need to improve
 - 8. Don't know
 - 9. Other (specify) _____
-

4. Do you think NCOs at this post should be given more, the same, or less training/orientation about drugs and alcohol to help them handle the problems of their people in an effective manner, or not? (Check only one) (33)

- 1. More than now 3. Less than now
- 2. Same as now 4. Don't know/no opinion

5. Do you think NCOs at this installation should receive training/orientation about drugs or alcohol which covers different subject matter, to help them handle the drug and alcohol problems of their people in an effective manner, or not? (Check only one)

- 1. Yes
- 2. No
- 3. Don't know/no opinion (34)

FORM I-2 (Continued)

6. In your opinion, what effect, if any, has drug/alcohol education at this post had on the use of drugs and alcohol among the E-1's through E-5's in your unit? (Check as many as apply for each column)

	(35) <u>Drugs</u>	(36) <u>Alcohol</u>
1. Not applicable - don't have education	____ 1.	____ 1.
2. No effect	____ 2.	____ 2.
3. Encouraged them to stay off	____ 3.	____ 3.
4. Encouraged them to cut down use	____ 4.	____ 4.
5. Encouraged them to <u>stop</u> using	____ 5.	____ 5.
6. Encouraged them to <u>increase</u> use	____ 6.	____ 6.
7. Encouraged them to <u>begin</u> using	____ 7.	____ 7.
8. Encouraged them to start using again	____ 8.	____ 8.
9. Encouraged them to switch from hard to soft drugs	____ 9.	____ 9.
0. Encouraged them to switch from soft to hard drugs	____ 0.	
X. Don't know	____ X.	____ X.

7. What is your opinion of the time devoted to drug and alcohol education for E-1s through E-5s at this post? (Check only one for each column)

	(37) <u>Drugs</u>	(38) <u>Alcohol</u>
1. About right	____ 1.	____ 1.
2. Too much	____ 2.	____ 2.
3. Too little	____ 3.	____ 3.
4. Should be eliminated	____ 4.	____ 4.
5. No opinion	____ 5.	____ 5.

FORM I-2 (Continued)

8. What is your opinion of the material covered in drug/alcohol education for E-1s through E-5s at this post? (Check only one)

1. It should be changed (39)
 2. It should remain the same
 3. Don't know/no opinion
 4. Not applicable - there is no drug/alcohol education for E-1s through E-5s at this post

Now two questions about yourself.

1. How old were you on your last birthday? (Check one)

1. 18 or younger 4. 23-25 7. 41-50 (40)
 2. 19-20 5. 26-30 8. Over 50
 3. 21-22 6. 31-40

2. What is your highest level of education, including accepted GED credits?
(Check one)

1. Grammar school 6. 1-3 years of college (41)
 2. Some high school 7. 4 years college/degree
 3. GED (high school equivalent) 8. Some graduate work
 4. High school graduate (diploma) 9. Graduate degree (masters, doctorate)
 5. Post-high-school trade/technical school (no college)

End of Card 2 $\frac{2}{80}$

Thank you for your help. If you have any other comments, please write them below.

FORM I-3

SAMPLE DATA COLLECTION FORM
EDUCATION PROGRAM EVALUATION

Identification No.

(1) (2) (3) (4)

1. Has respondent (R) had drug/alcohol education at this post?

_____ 1. Yes _____ 2. No (Go to Q.2) (5)

1.a. How many hours of education has R had? (6,7)
_____ hours

1.b. When was it completed? ____ / ____ /
mo. day yr. (8-13)

2. Was R confirmed as a problem drinker or drug user before education?

_____ 1. Yes _____ 2. No (Go to Q.3) (14)

2.a. How many times? _____ (15)

3. Has R been confirmed since education?

_____ 1. Yes _____ 2. No (Go to Q.4) (16)

3.a. How many times? _____ (17)

4. Did R have any disciplinary actions before education?

_____ 1. Yes _____ 2. No (Go to Q.5) (18)

4.a. How many times? _____ (19)

FORM I-3 (Continued)

5. Has R had any disciplinary actions since education?

1. Yes 2. No (Go to Q.6) (20)

5.a. How many times? _____ (21)

6. Did R receive an exemption before education?

1. Yes 2. No (Go to Q.7) (22)

7. Did R receive an exemption since education?

1. Yes 2. No (23)

8. Was R in rehabilitation program before education?

1. Yes 2. No (Go to Q.9) (24)

8.a. How many times? _____ (25)

9. Has R been in rehabilitation since education?

1. Yes 2. No (26)

9.a. How many times? _____ (27)

10. Experimental Status

1. Experimental 2. Control (28)

FORM I-4

SAMPLE DATA SUMMARY FORM: ALCOHOL AND DRUG EDUCATION PROGRAM EVALUATION

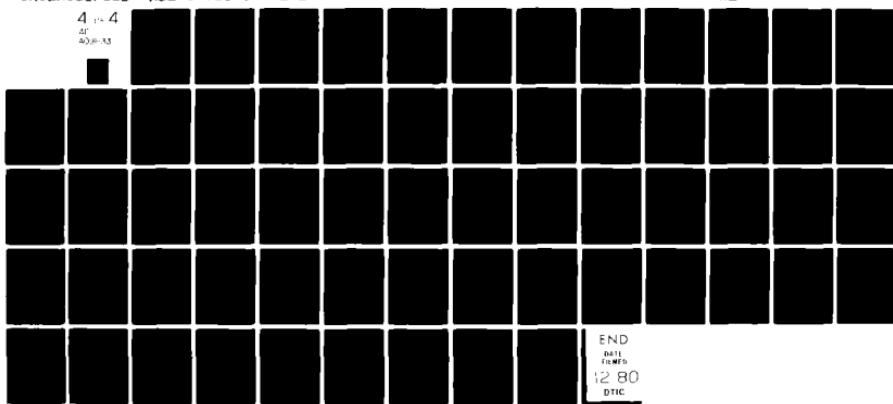
	<u>Experimental</u>	<u>Control</u>
1. Total number	_____	_____
2. No. confirmed before education	_____	_____
3. No. confirmed after education	_____	_____
4. No. where no. of confirmations before is less than no. after	_____	_____
5. No. where no. of confirmations before is equal to no. after	_____	_____
6. No. where no. of confirmations before is greater than no. after	_____	_____
7. No. with disciplinary actions before	_____	_____
8. No. with disciplinary actions after	_____	_____
9. No. where no. of disciplinary actions before is less than no. after	_____	_____
10. No. where no. of disciplinary actions before is equal to no. after	_____	_____
11. No. where no. of disciplinary actions before is greater than no. after	_____	_____
12. No. with exemptions before	_____	_____
13. No. with exemptions after	_____	_____
14. No. in rehabilitation before	_____	_____
15. No. in rehabilitation after	_____	_____

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APPENDIX J

MEASURING COSTS AND BENEFITS

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APPENDIX J

MEASURING COSTS AND BENEFITS

1. WHAT IS COST/BENEFIT ANALYSIS?

Cost/benefit analysis is a way of evaluating the usefulness of a program or strategy by measuring its results in comparison with its cost. In the case of an alcohol and drug abuse control program, it can help determine the effectiveness of a program modality--for example group therapy in rehabilitation or films in education. Cost/benefit analysis can be used to determine:

- (1) How the results achieved by a particular program modality compare with its cost;
- (2) Which of several program modalities provides the most value per dollar spent on it;
- (3) How the above relationships change from one year to the next.

This information can help program managers decide, on a yearly basis, which modalities are working the best and which ones may be more expensive than they are worth.

To permit a comparison of the effectiveness of modalities, a situation is needed in which the people whose progress will be assessed are not exposed to a mixture of modalities, or in which effectiveness is measured one modality at a time. Thus, if lectures are to be compared to film as a means of presenting information on alcohol side effects, the comparison must be made among individuals who have not been exposed to both at the time of the comparison. Similarly,

if one wants to compare individual and group therapy for drug rehabilitation, it is important that people who have received one have not received the other at the time of the comparison. Chapter V and Appendix H have discussed the monitoring of rehabilitation results at each stage in order to assess individual modalities. Another possibility is to establish experimental groups--subsets of the post population--each of which is exposed to a different modality.

The "cost" side of the cost/benefit relationship is obtained by measuring the dollar value of all "inputs"--staff, materials, and equipment--needed for a particular program modality. The "benefit" side is obtained by assigning numerical values to the possible "outputs"--or results--of the program modality. These outputs are measured in terms of program objectives. For example, if one objective of the drug rehabilitation program is the taking of no drugs for 30 days after completing the program, the output could be the number of soldiers who remain drug-free after 30 days.

Once both inputs and outputs have been put in numerical form, the cost/benefit calculation yields a figure for benefits per dollar of cost. One can then compare these figures for different program modalities--group therapy versus individual therapy in rehabilitation, for instance, or classes and lectures versus rap sessions in education--to see what differences there are in how much is accomplished per dollar spent. As discussed later, this does not automatically indicate what modalities should be used but it is an important aid in making that decision.

It is a good idea to keep track of changing inputs and outputs and to repeat the cost/benefit calculation annually. What is effective today may not be so effective in two years, or even if it is, something else may be even more effective.

2. DETERMINING INPUTS

a. Introduction

Before listing inputs and their costs it is important to define each program modality very clearly. Otherwise, costs cannot be accurately allocated to modalities and the resulting cost/benefit relationships will not be useful. It is impossible to avoid all spillover effects--situations in which a cost assigned to one modality really belongs partly to another (for instance in which therapy aimed at changing a person's drug habits also produces a change in his alcohol habits, or in which a staff member performs several functions and it is not possible to obtain an exact percentage breakdown of the time he devotes to each), but it is important to be aware of the problem and to guard against it as much as possible.

For purposes of analysis, modalities should be grouped into the following four categories, according to the purpose for which they are being used:

- (1) Education: Drug
- (2) Education: Alcohol
- (3) Rehabilitation: Drug
- (4) Rehabilitation: Alcohol

They should first be grouped under education and rehabilitation and then further subdivided between drugs and alcohol. When cost/benefit relationships are compared for individual modalities, each modality should be

compared only with others in the same category; for instance, slide shows, lectures, and posters can be compared as methods of drug education, and similar modalities can be compared as methods of alcohol education, but it is not useful to compare a drug slide show with an alcohol slide show since their objectives are not the same.

Once all modalities in each of the four groups have been identified and clearly defined, it is important to make sure that all inputs that go into any modality are included and to make sure that the quantity of each input is specified. Form J-1 and Form J-2 at the end of this appendix are sample forms for collecting this information. Use of the forms helps to ensure not only that the right kind of information is collected but also that standardized calculations can be made from year to year.

Form J-1 is for education modalities and Form J-2 for rehabilitation modalities. Each modality--"drug education slide show," "lecture program on alcohol abuse," "group therapy for drug users," etc.--should be entered on a separate form, but all the education modalities can use a form like Form J-1 and all the rehabilitation modalities can use one like Form J-2. While some modalities will be concerned either with drugs only or with alcohol only, others will address both alcohol and drugs. The input forms therefore, have space for separate entries for drugs and for alcohol. The inputs should be allocated between the entries for drugs and for alcohol in the same proportion as the number of persons served by the modality who have drug and alcohol problems. If, for example, half the persons treated by a particular rehabilitation modality are problem drinkers and half are drug users, then the various inputs, such as staff cost, will be allocated half to alcohol and half to drugs. In cases where a modality serves only one of the two programs the total

cost is entered under the column for that program. In the case of the education program, where the modalities are applied to groups of people who may or may not be either drug users or problem drinkers, there is an arbitrary way to split the cost of a modality addressing both drugs and alcohol--say, a series of rap sessions in which drug use and problem drinking are both discussed. If this situation arises, one simply enters half the inputs in each column since each objective received some (estimated at half) of the inputs.

To standardize the information and allow for comparison, all inputs are expressed in numbers and costs per year. The instructions below discuss how to do this and describe the two forms in more detail.

b. Education Inputs

For purposes of this discussion, assume that inputs are being calculated for the lecture modality in drug education. An education form like Form J-1 can be used. Since the lectures are about drugs only, no entries appear in the alcohol columns of the table. If the lectures were about both drugs and alcohol, one would enter half the costs in each column.

Although many of the staff used in the lecture program are not paid for directly by the drug program--for instance, post's legal staff--it is still important to include the estimated cost of their services, based on the number of hours per year that they spend preparing and teaching the course, times the annual salary rate they received, plus fringe benefits. If such "free" services are not included as costs,

there is no way to obtain cost/benefit relationships that can make valid comparisons between modalities or, for that matter, make sound estimates of the cost and benefits within a modality. Only when these free services are minimal can they be excluded.

To calculate materials and equipment costs, one first determines how long each item is expected to last. The original purchase price is then divided by the number of years to find the annual cost of the materials or equipment. This annual cost is entered in the table.

For the purpose of cost/benefit calculations, it will be necessary to add up the total cost of the modality and divide by the number of participants to obtain cost per participant. On Form J-1, since this is a drug modality only, these costs would be entered in the drug cost column. For a joint drug/alcohol modality half their value would be entered in the drug column and half in the alcohol column.

Displaying inputs in such a table is useful for other purposes besides cost/benefit calculations, in that it makes possible a variety of different comparisons that can be helpful in program planning. For example, one can compare staff hours with the number of people served, find out how much time different types of staff devote to the program, or compare equipment and materials cost with labor costs.

c. Rehabilitation Inputs

As an example of a rehabilitation modality, this discussion will use group therapy with both drug users and problem drinkers participating.

The rehabilitation form, Form J-2, has a special input item that

does not occur in education: the detoxification function. This is not a modality in itself. It is an input--a part of the cost of every rehabilitation modality--since anyone who needs detoxification must go through this process before he can enter any of the rehabilitation program modalities. The cost of detoxification is easy to calculate separately for drugs and for alcohol, since it is a matter of record which problem each patient was treated for. To determine the annual detoxification cost for each program modality, one needs to know how many of the people who participated in that program modality during the year had previously been detoxified for drugs and how many had been detoxified for alcohol. The medical staff may be able to furnish the cost per patient of detoxification; otherwise, it will need to be calculated on the basis of the number and yearly cost of detoxification personnel and the number of patients detoxified. If three of the people in group therapy during the year in question had been through alcohol detoxification, the detoxification cost of group therapy for the alcohol program in that year is three times this per-patient cost. If four other people had been detoxified for drugs, the detoxification cost of group therapy for the drug program is four times the per-patient cost.

The other cost inputs are divided between drugs and alcohol according to the relative proportions of individuals in group therapy who require drug rehabilitation and alcohol rehabilitation, regardless of how many have been detoxified. The rehabilitation form differs from the education form in that costs can be more clearly

assigned since the people participating in the program are all specifically identified as either drug users or problem drinkers. Separation of these costs is important to permit subsequent comparison of modalities for drugs separately from modalities for alcohol.

Again, the input form concludes with total cost and cost per person. These are obtained separately for drugs and for alcohol: costs are added and divided by the number of drug users treated, and alcohol costs are added and divided by the number of problem drinkers treated.

3. DETERMINING OUTPUTS

a. Introduction

Like inputs, outputs need to have values assigned to them. However, while inputs are valued at their annual dollar cost, outputs are assigned numbers on the basis of the objectives of the program modality and the extent to which these objectives are achieved.

The importance of formulating useful objectives cannot be overstated. On the one hand, they must be valid statements of what the education or rehabilitation program is trying to do. On the other, they must be possible to measure reasonably accurately in numbers. The process of setting up measurable objectives is discussed in Appendix E.

Outputs for education and rehabilitation program modalities are discussed separately below. Sample forms for entering education and rehabilitation outputs (Forms J-3 and J-4) appear at the end of this appendix.

b. Education Outputs

Drug and alcohol education can have three basic objectives: increasing knowledge, changing attitudes, and changing motor behavior (what people do). The ADAPCP may have different basic objectives for different groups of people--for example, enlisted men and the leadership structure--and provide a separate education program for each group, but for any one group, as discussed in Chapter IV of the handbook, it is best to decide which basic objective has top priority in the program and then choose program modalities to address that objective.

The next step is to develop operational measures of the basic objective chosen. For example, an operational measure of increased knowledge about drug side effects could be the amount of improvement in scores obtained on a multiple-choice test of these side effects, administered before and after exposure to the education program. An operational measure of attitude change about alcohol could be the amount of increase in the number of men indicating negative attitudes toward drunkenness. An operational measure of motor behavior change could be the amount of increase in the number of self-referrals for treatment.

The operational measures used for cost/benefit analysis are very similar to the operational objectives described in Appendix E except that instead of specifying a minimum performance level for judging whether the program has succeeded or not (e.g., "by the end of the program at least X percent of the men will obtain a score of Y percent or better on a multiple-choice test of drug side effects"), operational measures are concerned with how well it has succeeded (e.g., "by the end of the program, what is the average improvement in scores on a multiple-choice test of drug side effects by men exposed to different modalities?")

Appendix I discusses how to test for education program results and presents sample questions for each of the three basic education objectives. To simplify the scoring and cost/benefit calculation, the amount of improvement in each soldier's test results could be graded on a scale of perhaps 0 to 5. The scores for everyone exposed to a given modality are then added up and divided by the number of men to obtain the average score for that modality. This number is then entered on the output form, Form J-3. If more than one operational measure is being used--say, a test on knowledge of drug side-effects and a test on knowledge of legal consequences of drug use--each measure has its own column on the form with an average score for each modality.

The same set of operational measures must be used for all modalities being compared in drug education (for a given basic objective) and another set for all modalities being compared in alcohol education. It is important to use the same measures in order to have a standard for comparing the effectiveness of different modalities.

c. Rehabilitation Outputs

The rehabilitation program has only one basic objective: changing motor behavior. Several operational measures can be used for valuing the rehabilitation output for drugs and alcohol. For example, in drugs, possible operational measures include whether or not the individual is drug-free 30 days after the program, or one year after the program, or whether his job performance improves. It is advisable to use more than one measure--for example, the extent to which soldiers are drug free after 30 days and the extent to which their job performance has been improved.

When results for the two measures are entered on Form J-4, modalities may be found to rank differently for each. Group therapy, for example, might score higher than individual therapy on the measure of freedom from drugs for 30 days but lower on the measure of improved job performance. This kind of information can be extremely valuable both in evaluating the objectives that have been set and for long-term planning.

Appendix K describes how to test for rehabilitation results. As in the case of education, output values are expressed in terms of average improvement per soldier. For the objective of being drug-free for 30 days, for example, all soldiers found to be drug-free for 30 days could be given the number 1 and all who have not, the number 0. The scores for all soldiers in a particular modality would be added up and divided by the total number of soldiers in that modality.

Like the input tables, the output tables permit useful comparisons, whether or not a cost/benefit analysis is performed. They indicate how well each modality has worked and which modalities work best for different purposes.

4. CALCULATING AND USING BENEFIT/COST RELATIONSHIPS

Setting up the benefit/cost relationships or ratios is a relatively simple matter once the work has been done to determine inputs and outputs. It also provides a better instrument than either inputs or outputs alone for comparing different modalities. If one looks only at costs, one will tend to prefer that modality that has the least cost; if one looks only at benefits, one will tend to prefer that modality which has the highest

benefit. However, the least-cost modality may also produce the least benefits. Usually, the important thing to know is which modalities produce the greatest benefit for a given cost.

Form J-5 shows a format for entering benefit/cost ratios. Separate forms should be used for the education and rehabilitation programs, but they are set up the same way.

The ratios are easy to calculate. From the input tables, one enters the cost per person exposed to each modality, and from the output tables, one enters the benefit figures for each measure used. To get the benefit/cost ratio, one divides the benefit figure by the cost per person. Thus, each benefit/cost ratio shows the benefit per dollar spent per soldier for each program modality. In each of the four program categories (drug education, alcohol education, drug rehabilitation, and alcohol rehabilitation), the modality with the highest ratio is the best one from the viewpoint of the cost/benefit analysis.

It is important to remember that cost/benefit analysis is only a tool and should not be the sole basis for program decision. Cost/benefit analysis helps to sharpen understanding about program modalities, and the cost breakdowns and definitions of objectives that it requires are extremely useful in themselves. Much is gained by having concrete numbers for comparing various modalities. However, cost/benefit analysis is an approximate tool. A variety of errors can creep into the process of determining input costs or setting up operational measurements for outputs. Also, one may not always want to give preference to the modality with the highest benefit/cost ratio. For example, an objective may be considered so important that the modality yielding the highest benefit should be used regardless of cost.

Or resources may be much more readily available for one modality than for another. Decisions on program changes should not be made without considering such additional factors.

When the benefit/cost ratios indicate extremes, showing some modalities with very low benefit/cost ratios compared to others in the same category, there is good reason for considering whether to drop the low-ratio modalities. Often, however, the ratios are likely to cluster, indicating that the modalities all have about the same relationship of benefits and costs. If one wants to reduce the number of modalities, it is then helpful to examine the input and output tables to see whether, for some modalities both costs and benefits are unusually high or unusually low. One can then decide on the basis of how important the benefits are considered to be and what the program is able to afford.

The more often one uses cost/benefit analysis, the more skilled one becomes in using it effectively. It can be used in a wide range of ways to improve program planning, but the full range can be learned only through practice and over time.

FORM J-1

SAMPLE COST/BENEFIT INPUT FORM: EDUCATION

Program Modality: Lecture Program on Effects of Drugs

Year: _____

Number of Persons Receiving
Program During Year: _____Drug _____
Alcohol _____

INPUT ITEM	HOURS PER YEAR	COST IN DOLLARS PER YEAR	DRUG COMPONENT		ALCOHOL COMPONENT	
			HOURS PER YEAR	DOLLARS PER YEAR	HOURS PER YEAR	DOLLARS PER YEAR
<u>Staff</u>						
ADAPCP Staff:						
1. (name)						
2.						
3.						
4.						
5.						
<u>Legal Staff:</u>						
1.						
2.						
3.						
<u>Law Enforcement Staff:</u>						
1.						
2.						
3.						
<u>Medical Staff:</u>						
1.						
2.						
3.						
<u>Other:</u>						
1.						
2.						
3.						
<u>Materials</u>						
<u>Books:</u>						
1. (title and quantity)						
2.						
3.						
<u>Special Pamphlets:</u>						
1. (title and quantity)						
2.						
3.						
<u>Periodicals:</u>						
1. (title and quantity)						
2.						
3.						
<u>Motion Picture Films:</u>						
1. (title and quantity)						
2.						
3.						
<u>Slides:</u>						
1.						
2.						
3.						
<u>Other:</u>						
1.						
2.						
3.						
<u>Writing Materials:</u>						
1. (type and quantity)						
2.						
3.						
<u>Equipment</u>						
1. Slide Projector(s)						
2. Film Projector(s)						
3. Projection Screen(s)						
4.						
5.						
6.						
<u>TOTAL COST PER YEAR</u>						
<u>TOTAL COST PER PERSON</u>						

Note: Spaces on the form which are not applicable in this case have been X'd out. Some of the other spaces may or may not be applicable.

SAMPLE COST/BENEFIT INPUT FORM: REHABILITATION

Program Modality: Stop Therapy for Drug Users and alcohol Abusers
 Year: _____

Number of Persons Receiving
 Program During Year: Drug _____
 Alcohol _____

INPUT ITEM	HOURS DURING YEAR (Staff Only)	COST IN DOLLARS FOR YEAR	DRUG COMPONENT		ALCOHOL COMPONENT	
			HOURS DURING YEAR	DOLLARS FOR YEAR	HOURS DURING YEAR	DOLLARS FOR YEAR
<u>Detoxification</u>						
Drug: _____ Persons	X	\$ _____ /Person				
Alcohol: _____ Persons	X	\$ _____ /Person				
<u>Staff</u>						
ADAPCP:						
1. (name) _____						
2. _____						
3. _____						
4. _____						
<u>Other:</u>						
1. _____						
2. _____						
3. _____						
4. _____						
<u>Materials</u>						
1. (type and quantity) _____		/				
2. _____		/				
3. _____		/				
4. _____		/				
<u>Equipment</u>						
1. (type and quantity) _____						
2. _____						
3. _____						
4. _____						
<u>TOTAL COST PER YEAR</u>						
<u>COST PER PERSON</u>						

Note: Spaces that are not applicable have been X'd out. Others may or may not apply.

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FORM J-3

SAMPLE COST/BENEFIT OUTPUT FORM: EDUCATION

MODALITY	AVERAGE SCORE: DRUG		AVERAGE SCORE: ALCOHOL	
	<u>Measure No.1</u>	<u>Measure No.2</u>	<u>Measure No.1</u>	<u>Measure No.2</u>
Lecture Course				
Rap Sessions				
Reading Materials				
Film				
Slide Show				
(Etc.)				

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FORM J-4

SAMPLE COST/BENEFIT OUTPUT FORM: REHABILITATION

MODALITY	AVERAGE SCORE: DRUG		AVERAGE SCORE: ALCOHOL	
	<u>Measure No.1</u>	<u>Measure No.2</u>	<u>Measure No.1</u>	<u>Measure No.2</u>
Individual Therapy				
Group Therapy				
TM				
(Etc.)				

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FORM J-5
SAMPLE FORM FOR BENEFIT/COST CALCULATIONS

Program: (Education or Rehabilitation)

MODALITY (from Form J-1 or J-2)	COST PER PERSON Drug Alcohol	BENEFITS: DRUG (from Form J-3 or J-4)	BENEFITS: ALCOHOL (from Form J-3 or J-4)	BENEFIT/COST RATIO:	
		DRUG Measure No.1	ALCOHOL Measure No.2	Measure No.1	Measure No.2

MODALITY (from Form J-1 or J-2)	COST PER PERSON Drug Alcohol	BENEFITS: DRUG (from Form J-3 or J-4)	BENEFITS: ALCOHOL (from Form J-3 or J-4)	BENEFIT/COST RATIO:	
		DRUG Measure No.1	ALCOHOL Measure No.2	Measure No.1	Measure No.2

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APPENDIX K

MEASURING RESULTS: REHABILITATION

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APPENDIX K

MEASURING RESULTS: REHABILITATION

There are several ways to measure the results of rehabilitation. The experimental design method (pre- and post- tests, as suggested in Appendix I on measuring results of the education program) is not appropriate here because of lack of control groups and also the difficulty of obtaining pre-rehabilitation information. However, one can track rehabilitation "graduates" over time (which we would recommend), or one can review their situation once, at a given point in time. Appendix H, which deals with rehabilitation program monitoring, includes data collection instruments for use in assessing results at stages during the rehabilitation process. The present appendix is concerned with the overall effects of the program.

Surveys and post records can both be used as data sources. If soldiers have been randomly placed in two or more different types (modalities) of rehabilitation program, one can also compare the effectiveness of each program modality to determine which is most effective in meeting objectives. In any case, the instruments would be much the same. Wherever there would be differences in procedure, they are noted.

1. WHO SHOULD BE SURVEYED

In any of the above situations, there will be two populations to survey: rehabilitation "graduates" and their immediate supervisors.

The reason for surveying both is that each has a particular bias. On the one hand, it is in the best interests of the soldier to proclaim the

positive benefits of the rehabilitation. On the other, the supervisor may be biased against substance abusers and may fail to recognize genuine changes in behavior (in keeping with the theory of cognitive dissonance, which holds that when people are faced with evidence that conflicts with a firmly held belief/attitude/opinion, they may discount the evidence by repression, rationalization, or some other means).

Ideally, all rehabilitation "graduates" and their supervisors should be surveyed to guard against misleading results. If this is not feasible, a representative sample of "graduates" can be chosen. Section 2 of Appendix D describes methods of obtaining a random sample.

Although it is obvious that the larger the sample, the more reliable the results, a number of other considerations--resources available, degree of precision desired, inherent variability of the data, methods to be used in analyzing the data--will all affect sample size. Whatever size group is used, it is strongly recommended that the group be surveyed repeatedly following completion of the program--perhaps every four or six months--to provide information on the program's effectiveness over time.

If two or more rehabilitation programs or treatment modalities are to be compared, the same principles apply. It should also be mentioned that there is no need to obtain an equal number of respondents for each modality. Valid estimates, tests, and comparisons can be made from two or more sets of sample data which are unequal in size. However, it is important that random sampling techniques be employed for each group of "graduates" and that the groups be surveyed under similar conditions.

The immediate supervisors of rehabilitated personnel are not randomly selected. They constitute a "purposive" sample, in that they are chosen because they are the supervisors of rehabilitation "graduates" in the "graduate" sample. It is assumed that all supervisors of "graduates" can be surveyed for attitudinal information, so that sample size will be of no concern.

2. WHAT RECORDS TO REVIEW

In addition to these subjective responses, objective information can be obtained from soldier records: disciplinary actions incurred before and after rehabilitation, identification as a drug user or problem drinker *after* rehabilitation, and so on. Since events immediately following rehabilitation could in part reflect bias operating against soldiers who have been in rehabilitation, again it is desirable to track a sample of rehabilitation entrants over time, in this case to answer such situations as: How many "graduate" (complete the program) and how many drop out? How many stay in the Army and how many are discharged? Of those discharged, how many are discharged before their term of service is up? Of those discharged, how many receive other than honorable discharges? Of those remaining in the Army, how many are returned to their unit and how many are transferred? Of those remaining in the Army, how many are given different jobs? Of those remaining in the Army, how many re-enter rehabilitation? Of those remaining in the Army, how many have reduced pay grades; how many have pay grade increases, and how many stay the same? Figure K-1 shows the relationships among these items of information.

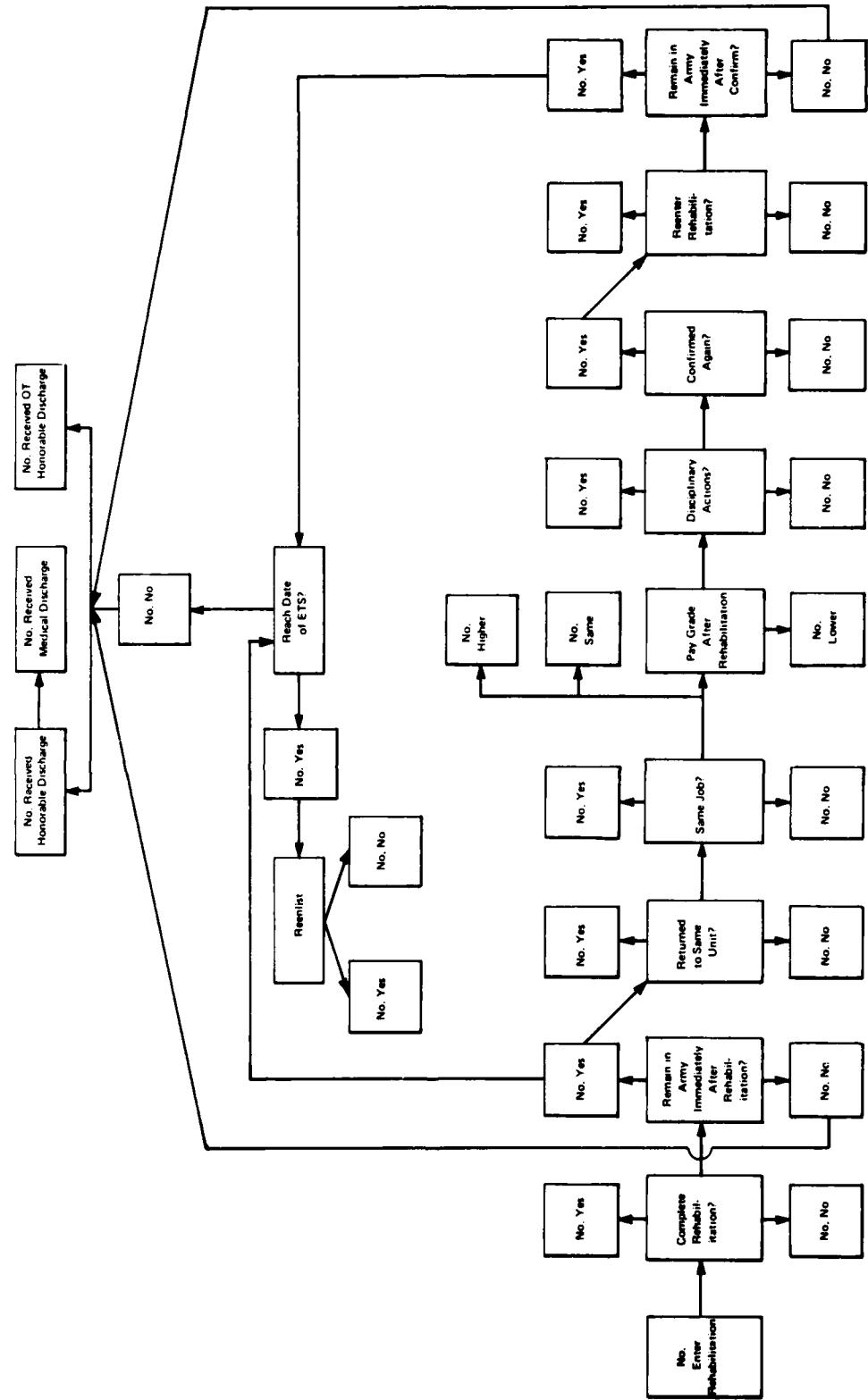


FIGURE K-1 TRACKING REHABILITATION ENTRANTS OVER TIME

The number of soldier records to be examined as objective indicators of program effectiveness--and the usefulness of the records--depends on their availability, accessibility, and completeness. If the data shown in Figure K-1 are maintained in computer processable form, summary tables and statistics can be readily generated for all relevant personnel. If, however, the retrieval of this information is performed manually, it will again be necessary to use sound statistical sampling practices to select representative data on rehabilitated individuals.

It is recommended that as much of this information as possible be obtained from the start. Subsequent analyses should reveal important relationships, and improvements in the data collection activity can be made over time. It is suggested that someone knowledgeable in statistical methodology be consulted for the design and analysis effort required in planning the data collection.

3. HOW TO CONDUCT THE SURVEY

Normally, there are three ways to survey populations: by face-to-face interview, by telephone interview, or by self-administered questionnaire. In this instance, the size of the sample may permit interviews. If self-administered questionnaires are used, Appendix D should be reviewed for guidance. The sample questionnaires included here could be self-administered with minor modifications.

a. The Interviewer

The person conducting an interview should *not* be in a position to penalize the drug user/problem drinker for any actions, attitudes, or beliefs. Someone in direct authority or with law enforcement responsibilities is

likely to get inaccurate information--the respondent will feel compelled to give some answer to questions but may tailor the answers to avoid possible punishment. Conversely, the person interviewing a commanding officer should not be under his command or feel intimidated in any way by his rank.

The interviewer must know how to use the exchange as a means of information gathering rather than a means of changing attitudes and behavior. He must avoid showing approval or disapproval of statements made by the respondent. The tone should be friendly but neutral. Courses in interpersonal behavior, group dynamics, and so on, are very helpful preparation for such a role.

The interviewer should not interpret the meaning of a question for a respondent but should say "Whatever it means to you." He should never express an opinion as to a question, the value of the survey, etc. Where an answer is unclear, nondirective probes should be used (e.g. "What do you mean by that?" or "I'm not sure of your response. Let me repeat the question."). Interviewers should be thoroughly familiar with the instrument.

b. The Setting

The setting helps set the tone of the interview. Rather than sitting across a desk from one another, the interviewer and respondent should sit in comfortable chairs facing each other without intervening furniture barriers or other unnecessary indications of rank/status. A "neutral" spot, such as a meeting room, is preferable to the territory of either party (e.g. the ADCO's office, the soldier's recreation room). Privacy is also essential.

c. Conditions

Anonymity must be preserved. There should be no question asked which could identify the respondent, and once the research is concluded, the lists of respondents should be destroyed.

d. Approach

At the end of this appendix are two sample interview schedules, one (Form K-1) for "graduates" of the rehabilitation program and one (Form K-2) for supervisors. These may be appropriate to a particular ADAPCP, or program staff may wish to modify them or to design others.

Section 3 of Appendix D discusses the organization and wording of self-administered questionnaire items. The same guidelines apply to interviewer-administered questionnaires: they should be primarily "closed-end," written in simple, clear language, with questions following a logical pattern and usually going from general to more specific. Sensitive questions should not be asked at the very beginning of the interview, should be worded in a way that implies an equal probability for all answers, and may sometimes be accompanied by sanctioning statements. In changing topics, a transitional sentence helps -- e.g., "Now, a few questions about yourself."

The interview format should be similar to that used for a self-administered questionnaire, as described in Section 3-f of Appendix D; the keypunch form is preferable to the mark sense. The questionnaire should be precoded if it is to be computer-processed. The layout should be clean and uncluttered, questions should be distinguished from instructions by different kinds of type, and questions should not be split up between pages

except where they run longer than a full page. As discussed in Section 3-c of Appendix D, it may be desirable to make consistency checks and order-bias checks.

Where a question includes a number of items to be asked about, it is useful to hand cards to the respondent. The interviewer still records the answers on the form, but the respondent is able to see what he is being asked.

The interview should have an introduction giving information about why the survey is being conducted and what will be done with the data (stressing anonymity). There should also be a set of instructions informing the interviewer about how to proceed. Interviewers should be briefed on procedures.

The interview number can be used to match "graduates" with supervisors. If fewer than 1000 respondents are in each sample, for example, "graduates," can be labeled starting with 1000. Matched to each "graduate" by the same number *except* the first digit, would be supervisors. Thus, respondent 1005's supervisor would be 2005, and so on.

e. Types of Question

The "graduate" survey is primarily concerned with knowledge and attitudes; the supervisor survey asks primarily about behavior/attitude change on the part of the "graduate." When designing a survey to measure attitudes, it is advisable to consult some of the works that have been written on the subject.¹

¹See, for example, John P. Robinson and Phillip R. Shauer, Measures of Social Psychological Attitude (Ann Arbor: Survey Research Center, University of Michigan, 1969); and Claire Seltz, Marie Johoda, Morton Deutsch, and Stuart W. Cook, Research Methods in Social Relations (New York: Holt, Rinehart and Winston, 1959), pp. 243-55, 279-314, 343-384. See also Inventory--Drug Abuse Research Instrument (Cambridge, Mass., January 1972); Research Reference Files; and ERIC Clearinghouse for Tests, Measurement, and Evaluation.

f. The Trial Pretest

Before beginning the interview process on a large scale, one should test each form by interviewing several respondents in each group ("graduates" and supervisors) under actual conditions. The time to administer should be noted (one hour is considered maximum), and interviewers should go over each question with respondents to get their reactions as to clarity, inclusiveness of response categories, logic of asking the question, and so on. The schedules can then be revised, printed and made ready for the survey.

4. WHAT TO DO WITH THE DATA

Appendix D, Section 4, describes the first steps after the forms have been filled out. They must be reviewed and corrected for double answers or other problems, and a computer "edit" should be done if the results are to be processed by computer (this may depend on the size of the sample). Straight tabulations should then be made showing the number and percent of respondents checking each response.

a. Cross-Tabulations

Cross-tabulations of the data can then be run. These can be of several types, including responses by background data (e.g. age, marital status), consistency checks (response to one question by response to another), and cross-tabulating of one attitude against another or an attitude against behavior, or of behavior against behavior. Table K-1 shows examples of cross-tabulations.

b. Interpreting the Results

A number of statistical methods are available to enable conclusions

TABLE K-1

EXAMPLES OF CROSS-TABULATIONS

1. Response by Background Data

Whether or not first time in treatment, by sex

	<u>Male</u>	<u>Female</u>
First time	X	X
Second time or more	X	X

2. Consistency Check

Attitudes toward whether or not should have been in treatment
by helpfulness in getting off drugs

(This is also an example of cross-tabulating two attitudes)

Should Have Been in Treatment?	Helpful in Getting Off Drugs				
	Excellent	Good	Poor	Very Poor	No Opinion
Yes	X	X	X	X	X
No	X	X	X	X	X

TABLE K-1 (Continued)

3. Behavior Versus Behavior

Disciplinary actions before treatment
by disciplinary actions after

<u>No. Before</u>	<u>No. After</u>					
	0	1	2-3	4-6	7+	DK
0	X	X	X	X	X	X
1	X	X	X	X	X	X
2-3	X	X	X	X	X	X
4-6	X	X	X	X	X	X
7+	X	X	X	X	X	X
DK	X	X	X	X	X	X

Disciplinary actions after treatment
by treatment modality

<u>No. of Actions</u>	<u>Group Therapy</u>	<u>Individual Therapy</u>
0	X	X
1	X	X
2-3	X	X
4-6	X	X
7+	X	X
DK	X	X

to be derived from survey and other data. One of these, the Chi-square (χ^2) test to determine whether two variables are related or independent, has been described and illustrated in both Appendix D and Appendix I. Another, the t-test, or test of equality of means, was introduced in Appendix I and is described again here because of its usefulness in before-and-after measurements. The description here is intended to be understood by a reader with some mathematical training but no statistics. If the ADAPCP has access to statistically trained people, however, it is simpler to let them handle the data analysis.

The t-test enables one to determine whether the difference between two averages is statistically significant. Suppose, for example, that one wants to determine whether or not the occurrence of disciplinary action has declined, on the average, following treatment. Formulating the problem in statistical terms, one wants to test the hypothesis that the average number of disciplinary actions after rehabilitation is no different from the average before. To perform this test, results of the two sets of sample data (before and after) are utilized to compute a test statistic. The value of this statistic is then compared to a theoretical value (see Table K-2) based on the assumption that there is, in fact, no difference between the two data sets. If the test statistic computed from the data differs from the theoretical value, the hypothesis is rejected and one can conclude that a significant change in disciplinary action has occurred.¹

1

Underlying assumptions and computational procedures required to perform tests of the equality of means are described in most statistical methods texts; for example, see Bernard J. Ostle, Statistics in Research (Ames, Iowa: Iowa State College Press, 1956) or Irwin Miller and John E. Freund, Probability and Statistics for Engineers (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1965).

To illustrate the concept of testing for equality of means, suppose that seven randomly selected individuals, interviewed at the start of drug rehabilitation, reported that they had been "frequently involved" in disciplinary action over the prior one-year period. In addition, suppose that six other randomly selected individuals, interviewed a year after completing the program, reported less involvement in disciplinary action. (In reality, sample sizes would be much larger; however, small samples are used here to illustrate computational techniques.) As a consequence, it would be of interest to determine whether the differences are "random" in the sense that they can normally be expected from two different samples, or "significantly different" in the sense that the two sample groups actually exhibit different behavioral patterns. The t-test is a statistical procedure that can be used to resolve this issue.

The computational procedure can be illustrated with the following data:

NUMBER OF DISCIPLINARY ACTIONS FOR EACH PERSON
(Most Recent 12 Months)

<u>Sample Group Enrolled in Rehabilitation Program</u>	<u>Sample Group Completing Rehabilitation Program</u>
10	5
5	0
9	6
8	3
9	5
4	6
6	

To perform a t-test to see if the two groups differ in terms of disciplinary action, the following three quantities must be calculated:

- (1) Average number of disciplinary actions for the first sample group: (\bar{x}_1).

$$\frac{10 + 5 + 9 + 8 + 9 + 4 + 6}{7} = \frac{51}{7} = 7.28$$

- (2) Average number of disciplinary actions for the second sample group: (\bar{x}_2).

$$\frac{5 + 0 + 6 + 3 + 5 + 6}{6} = \frac{25}{6} = 4.17$$

- (3) Measure of the variability of the data, designated as the pooled estimate of the common variance: (s^2). This is calculated as follows:

- (a) Take the number of actions observed for each person in group 1 and subtract the average value (\bar{x}_1), then square the result. Example: $(10 - 7.28)^2$.

- (b) Add the results for all 7 individuals.

- (c) Repeat for group 2 using the average value (\bar{x}_2).

- (d) Add together all the results for the two groups.

- (e) Divide by the following quantity: number of persons in group 1 plus number of persons in group 2 minus number of groups.

Thus:

$$S_2 = \frac{\overline{(10 - 7.28)^2 + (5 - 7.28)^2 + \dots + (6 - 7.28)^2}}{7 + 6 - 2} \\ + \overline{(5 - 4.17)^2 + (0 - 4.17)^2 + \dots + (6 - 4.17)^2} \\ = \frac{31.43 + 26.83}{11} \\ = 5.29$$

Next, the test statistic is calculated as follows:

$$t = \frac{\bar{x}_1 - \bar{x}_2}{\sqrt{\frac{s^2}{n_1} + \frac{s^2}{n_2}}}$$

where n_1 is the number of observations in the first group, and n_2 is the number of observations in the second group. Thus, in the example,

$$t = \frac{7.28 - 4.17}{\sqrt{\frac{5.29}{7} + \frac{5.29}{6}}} = \frac{3.11}{\sqrt{1.637}} = 2.43$$

If one is willing to risk being wrong no more than 5% of the time (that is, test at a 5% significance level), the computed value of 2.43 is compared with the appropriate tabular value given in Table K-2.

TABLE K-2

t-TABLE AT 5% RISK LEVEL

<u>Degrees of Freedom</u>	<u>Tabular t-Value</u>
1	12.706
2	4.303
3	3.182
5	2.571
10	2.228
11	2.201
20	2.086
50	2.008
100	1.984
500	1.965

Expanded tables appear in most statistical texts, but Table K-2 is sufficient to demonstrate the method.

In order to look up the proper value in Table K-2, one needs to know the degrees of freedom as well as the risk level. For problems involving two groups, degrees of freedom are $(n_1 + n_2 - 2)$, or 11 in this case. Thus, the tabular value of interest is 2.201. This is smaller than the t-value, indicating that the difference between the two groups is statistically significant rather than random. The interpretation of hypothesis testing is that the computed value of 2.43 is very unlikely to occur (that is, with less than a 5% chance), if, in fact, the two groups are no different in terms of disciplinary actions. Thus, it could be concluded that the rehabilitation program has had a favorable effect on the participants in terms of improved behavior.

Other standard statistical methods, such as regression and correlation analysis, should be applicable for interpreting the data. These and other techniques, far too numerous to describe in this handbook, are described in detail in the texts that have been cited.

5. QUESTIONS TO BE ANSWERED FROM THE SURVEYS AND POST RECORDS

In performing the statistical work discussed above, one needs to have in mind a set of questions to be answered. Examples of such questions are given below:

I. What percent of entrants complete the program? (From records)

II. What differences, if any, are there in what happens to "dropouts" vs. what happens to "graduates"? (Records)

- A. Disciplinary actions
- B. Paygrade changes
- C. Further identifications
- D. Further treatment
- E. Discharges
 - o Early - honorable, medical, other than hon./med.
 - o Regular - honorable, medical, other than hon./med.
- F. Returned to unit/transfers
- G. Given same job/given different job

III. What differences, if any, are there in what happens to "graduates" (Records) vs. what is reported to happen (surveys)?

- A. Disciplinary actions (Records vs. supervisor survey)
- B. Paygrade changes (Records vs. "graduate" survey)
- C. Further identifications (Records vs. supervisor survey)
- D. Returned to unit/transferred (Records vs. "graduate" survey)
- E. Same job/different job (Records vs. "graduate" survey)

IV. What demographic or other differences, if any, are there related to what happens to "graduates" ("Graduate" and supervisor surveys)

- A. Disciplinary actions
- B. Paygrade changes
- C. Further identifications
- D. Returned to unit/transferred
- E. Same job/different job
- F. Perceived changes in discipline
- G. Perceived changes in fighting
- H. Perceived changes in peer group relations
- I. Perceived changes in drug/alcohol behavior

by: present service status; present active duty status; type of unit; length of service; career orientation; time at the post; former place of residence; whether or not live on the post; ethnicity; marital status; sex; education; type of drug for which treated; whether or not first treatment; length of time using drug; length of time out of treatment

V. How did "graduates" perceive the program? ("Graduate" survey)

- A. Whether or not should have been in treatment
- B. Rating of help in stopping substance abuse
- C. Rating of help in "getting self together"
- D. Rating of treatment as a person
- E. Most helpful treatment types
- F. Least helpful treatment types
- G. Most helpful staff
- H. Least helpful staff
- I. Percent of those in rehabilitation needing treatment
- J. Helping others stop substance abuse
- K. Helping others reduce substance abuse
- L. Helping others switch drugs

by: length of time in treatment; type of treatment received; length of time out of treatment; demographic variables listed under IV; type of staff in contact with

VI. What difference exists between "graduate" perception and "supervisor" perception? ("Graduate" and supervisor surveys)

- A. Helping others stop substance abuse/helping "grad."
stop substance abuse
- B. Helping self stop substance abuse/helping "grad."
stop substance abuse
- C. Helping others reduce substance abuse/helping "grad."
reduce substance abuse
- D. Helping others switch drugs/helping "grad." switch drugs
- E. Whether or not should have been in treatment

6. SAMPLE FORMS

On the following pages are sample interview schedules and data collection instruments for post records. Form K-1 is an interview questionnaire for "graduates" and Form K-2 is one for supervisor. Form K-3 is a form for recording post records on each individual, and Form K-4 a data summary sheet organized in the manner shown in Figure K-1. If a computer is used for calculations, the summary sheet can be simplified to display only results.

Data on the summary sheet, Form K-4, can be used to answer many questions. For example one may wish to compare the proportion of honorable discharges among:

- (a) Those who are discharged from the Army immediately after their first rehabilitation at the post; and,
- (b) Those who are discharged immediately after their second rehabilitation.

The proportion (a) is obtained by dividing item 32 of Form K-4 into item 39. Proportion (b) is item 42 divided by item 34.

FORM K-1

SAMPLE INTERVIEW FOR REHABILITATION "GRADUATES":

KEYPUNCH VERSION

"GRADUATE" INTERVIEW

<hr/>	<i>Interviewer</i>	<i>Interview No.</i>	<hr/>
<hr/>	<i>Day/Date</i>	(1) (2) (3) (4)	
			<i>Time Begun</i>

I. INTRODUCTION

(Introduce yourself) We are conducting a study of programs on this post dealing with problems of drugs and alcohol.

Your answers to this questionnaire will be held in the strictest confidence. They will not be available to your supervisors, NCOs, or officers. Your answers to this survey will help the Army to develop better drug/alcohol programs.

You were chosen for this interview through a random selection of personnel who have recently participated in drug or alcohol treatment or rehabilitation programs on this post. Have you, in fact, recently participated in such a program? *(Check one)*

1. Yes *(Continue to Q.1)* (5)
 2. No *(Terminate)*

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FORM K-1 (Continued)

II. BACKGROUND

First, I'd like to get some general background information about you.

1. What is your present service status: Are you in technical/occupational training, do you have a permanent duty assignment, or what? (Check one)

1. Technical/occupational training Skip to Q.2) (6)
 2. Permanent duty assignment (Go to Q.1a)
 3. Other (specify) _____ (Skip to Q.2)

- 1a. Is this your first duty assignment, or not? (Check one) (7)
 1. Yes 2. No

2. What is your present active duty status: regular or reserve?

1. Reserve
 2. Regular (8)

3. What is your present paygrade?

1. E-1 4. E-4 (9)
 2. E-2 5. E-5
 3. E-3 6. E-6 or higher

4. All told, how long have you been in the Army? (Check one)

1. 6 months or less 5. Over 5 years to 10 years (10)
 2. Over 6 months to a year 6. Over 10 years to 20 years
 3. Over a year to 3 years 7. Over 20 years
 4. Over 3 years to 5 years

FORM K-1 (Continued)

5. How much more active duty time do you have to serve on your current enlistment or obligation? (Check one)
1. 6 months or less 4. Over 2 years to 3 years (11)
 2. Over 6 months to 1 year 5. Over 3 years
 3. Over a year to 2 years
6. Do you plan to remain in the service when your commitment is up, or not? (Check one)
1. Yes 2. No 3. Don't know (12)
7. Do you plan to make a career of the military service, or not? (Check one)
1. Yes 2. No 3. Don't know (13)
8. How long have you been at this post? (Check one)
1. 3 months or less 4. Over 1 year to 2 years (14)
 2. Over 3 months to 6 months 5. Over 2 years to 3 years
 3. Over 6 months to one year 6. Over 3 years

Form K-1 (Continued)

9. (*Hand Respondent Card A*) In which one of the following types of places did you live just before you entered the Army? (Check one)

- 1. A farm/ranch (15)
- 2. In country, not farm/ranch
- 3. Town/small city (less than 25,000 people then)
- 4. Medium city (25,000 - 100,000 people then)
- 5. Large city (over 100,000 people then)
- 6. Suburb of a large city
- 7. Suburb of a small/medium city

CARD A

- 1. A farm/ranch
- 2. In the country but not a farm/ranch
- 3. Town/small city (less than 25,000 people then)
- 4. Medium city (25,000-100,000 people then)
- 5. Large city (over 100,000 people then)
- 6. Suburb of a large city
- 7. Suburb of a small/medium city

FORM K-1 (Continued)

10. Do you live on or off this post? (Check one)

1. On post 2. Off post

(16)

11. (Mark respondent's apparent ethnicity)

- 1. Spanish/Mexican American
 - 2. White (other than Spanish/Mexican American)
 - 3. Black
 - 4. Oriental American
 - 5. American Indian
 - 6. Other (specify) _____

(17)

12. What is your marital status? (Check one)

1. Married 3. Divorced 5. Single
 2. Legally Separated 4. Widowed (never married)

(18)

13. How old were you on your last birthday? (Check one)

1. 18 or less 4. 25 7. 28-35
 2. 19-21 5. 26 8. 36-40
 3. 22-24 6. 27 9. Over 40

(19)

14. (Mark respondent's sex)

(20)

15. What is your highest level of education, including accepted GED credits? (Check one)

- | | |
|--|---|
| <input type="checkbox"/> 1. Grammar school | <input type="checkbox"/> 6. 1-3 years of college |
| <input type="checkbox"/> 2. Some high school | <input type="checkbox"/> 7. 4 years college/degree |
| <input type="checkbox"/> 3. GED (high school equiv.) | <input type="checkbox"/> 8. Some graduate work |
| <input type="checkbox"/> 4. High school graduate
(diploma) | <input type="checkbox"/> 9. Graduate degree (masters,
doctorate, etc.) |
| <input type="checkbox"/> 5. Post-high school trade/
technical school (no college) | |

(21)

Form K-1 (continued)

III. TREATMENT/REHABILITATION

I'd like to turn now to the treatment/rehabilitation program here at this post, which I'll call "Rehabilitation."

1. Was this your first time in rehabilitation, or not? (Check one)

1. First time 2. Two or more times

2. How did you happen to enter rehabilitation? Did you volunteer, were you ordered, were you referred, or what? (Check one)

1. Volunteered 3. Referred (23)
 2. Ordered 4. Other (specify) _____

3. (Hand Respondent Card B) For which of these substances did you get placed into rehabilitation? (Check as many as apply)

1. Alcohol 7. Barbiturates (24)
 2. Marijuana/hash 8. Other downers
 3. Hallucinogens 9. Darvon
 4. Amphetamines 10. Methadone
 5. Cocaine X. Other opiates
 6. Other uppers

CARD B

1. Alcohol
2. Marijuana/hash.....pot, grass, hash, etc.
3. Hallucinogens.....LSD, mescaline, peyote, STP, DOM, THC, Sernyl, PCP, etc.
4. Amphetamines.....Benzedrine, Methedrine, Dexedrine, crystal, Ritalin, speed
5. Cocaine.....C, coke, dust, snow
6. Other uppers.....Preludin, any stimulant other than cocaine and amphetamines
7. Barbiturates.....Seconal, Nembutal, Amytal, "reds," "yellows," etc.
8. Other downers.....Doriden, Mandrax, Quaalude, Sopors, etc.
9. Darvon
10. Methadone.....Dollies, dolls
11. Other opiates.....Heroin, morphine, opium, Demerol, codeine

Form K-1 (continued)

Now, considering your (latest) rehabilitation:

4. How long before you entered rehabilitation had you been using the drug (or drinking too heavily) for which you were in rehabilitation? (Check one)
1. One month or less 4. Over 6 mos. to 1 year (25)
 2. Over 1 mo. to 2 mos. 5. Over 1 year
 3. Over 2 mos. to 6 mos.
5. Which of the following did you have: medical treatment, live-in rehabilitation/counseling, out-client counseling, detoxification, or what? (Check as many as apply)
1. Medical treatment (26)
 2. Live-in rehabilitation/counseling
 3. Out-client counseling
 4. Detoxification
 5. Other (specify) _____
6. How long were you in rehabilitation program? (Check one)
1. 1 week or less 4. Over 3 weeks to 1 month
 2. Over 1 week - 2 weeks 5. Over a month
 3. Over 2 weeks - 3 weeks 6. Other (specify) _____ (27)
7. How long have you been out of rehabilitation? (Check one)
1. 1 month or less 3. more than 3 mos. (28)
 2. more than 1 mo. to 3 mos. 4. more than 6 mos.
8. Do you think you should have been in rehabilitation, or not? (Check one)
1. Yes 2. No (29)

Form K-1 (continued)

9. Do you think rehabilitation was excellent, good, poor, or very poor at helping you to get off drugs, or stop drinking too much? (Check one)

1. Excellent 3. Poor 5. No opinion (30)
 2. Good 4. Very poor

10. Do you think it was excellent, good, poor, or very poor in helping you get yourself together? (Check one)

1. Excellent 3. Poor 5. No opinion (31)
 2. Good 4. Very poor

11. Overall, how would you rate the program staff: excellent, good, poor, or very poor? (Check one)

1. Excellent 3. Poor 5. No opinion (32)
 2. Good 4. Very poor

12. How good were the staff at treating you like a human being: excellent, good, poor, or very poor? (Check one)

1. Excellent 3. Poor 5. No opinion (33)
 2. Good 4. Very poor

Form K-1 (continued)

13. (Hand Respondent Card C) Which, if any, of the following types of treatment did you receive? (Check as many as apply)

- | | | | |
|--|------|---|------|
| <input type="checkbox"/> 1. Individual counseling | (34) | <input type="checkbox"/> 1. Halfway house | (35) |
| <input type="checkbox"/> 2. Group counseling | | <input type="checkbox"/> 2. Psychodrama | |
| <input type="checkbox"/> 3. Detoxification | | <input type="checkbox"/> 3. Transcendental meditation | |
| <input type="checkbox"/> 4. Encounter groups | | <input type="checkbox"/> 4. Work/job training therapy | |
| <input type="checkbox"/> 5. Transactional analysis | | <input type="checkbox"/> 5. Command consultation | |
| <input type="checkbox"/> 6. Rap center | | <input type="checkbox"/> 6. Rap sessions | |
| <input type="checkbox"/> 7. Value clarification | | <input type="checkbox"/> 7. Other (specify) | |
| <input type="checkbox"/> 8. Reality therapy | | | |

CARD C

Individual counseling
Group counseling
Detoxification
Encounter groups
Transactional analysis
Rap Center
Value Clarification
Reality Therapy
Halfway House
Psychodrama
Transcendental Meditation
Work/job training therapy
Command consultation (unit supervisor)
Rap sessions
Other (please specify)

Form K-1 (continued)

14. Which, if any, of those you've mentioned were most helpful to you?
(Check as many as apply)

- | | | | |
|--|------|---|------|
| <input type="checkbox"/> 1. Individual counseling | (36) | <input type="checkbox"/> 1. Halfway House | (37) |
| <input type="checkbox"/> 2. Group counseling | | <input type="checkbox"/> 2. Psychodrama | |
| <input type="checkbox"/> 3. Detoxification | | <input type="checkbox"/> 3. Transcendental meditation | |
| <input type="checkbox"/> 4. Encounter groups | | <input type="checkbox"/> 4. Work/job training therapy | |
| <input type="checkbox"/> 5. Transactional analysis | | <input type="checkbox"/> 5. Command consultation | |
| <input type="checkbox"/> 6. Rap center | | <input type="checkbox"/> 6. Rap sessions | |
| <input type="checkbox"/> 7. Value clarification | | <input type="checkbox"/> 7. Other (specify) | |
| <input type="checkbox"/> 8. Reality therapy | | | |

15. Which, if any, of those you've mentioned, were least helpful
to you? (Check as many as apply)

- | | | | |
|--|------|---|------|
| <input type="checkbox"/> 1. Individual counseling | (38) | <input type="checkbox"/> 1. Halfway House | (39) |
| <input type="checkbox"/> 2. Group counseling | | <input type="checkbox"/> 2. Psychodrama | |
| <input type="checkbox"/> 3. Detoxification | | <input type="checkbox"/> 3. Transcendental meditation | |
| <input type="checkbox"/> 4. Encounter groups | | <input type="checkbox"/> 4. Work/job training therapy | |
| <input type="checkbox"/> 5. Transactional analysis | | <input type="checkbox"/> 5. Command consultation | |
| <input type="checkbox"/> 6. Rap center | | <input type="checkbox"/> 6. Rap sessions | |
| <input type="checkbox"/> 7. Value clarification | | <input type="checkbox"/> 7. Other (specify) | |
| <input type="checkbox"/> 8. Reality therapy | | | |

Form K-1 (continued)

16. (Hand Respondent Card) Which, if any, of the following program personnel do you recall having contact with? (Check as many as apply)

- 1. Program director
- 2. General duty MD
- 3. Psychiatrists
- 4. Nurses
- 5. Social workers
- 6. Chaplains
- 7. Counselors other than former drug users/problem drinkers (40)
- 8. Counselors who were former drug users/problem drinkers.
- 9. Psychologists
- 10. Other (specify) _____

CARD D

- 1. Program director
- 2. General duty MD
- 3. Psychiatrists
- 4. Nurses
- 5. Social workers
- 6. Chaplains
- 7. Counselors other than former drug users/problem drinkers
- 8. Counselors who were former drug users/problem drinkers
- 9. Psychologists
- 10. Other (please specify)

Form K-1 (continued)

17. Which, if any, of those you mentioned were particularly helpful to you? (Check as many as apply) _____ (41)

1. Program director 6. Chaplains
 2. General duty MD 7. Counselors other than former
 3. Psychiatrists drug users/problem drinkers
 4. Nurses 8. Counselors who were former
 5. Social workers drug users/problem drinkers

 9. Psychologists

 10. Other (specify) _____

18. Which, if any, of those you mentioned were least helpful to you? (Check as many as apply) _____ (42)

1. Program director 6. Chaplains
 2. General duty MD 7. Counselors other than former
 3. Psychiatrists drug users/problem drinkers
 4. Nurses 8. Counselors who were former
 5. Social workers drug users/problem drinkers

 9. Psychologists

 10. Other (specify) _____

19. When you completed rehabilitation, were you returned to your same unit, or not? (Check one) _____ (43)

1. Yes 2. No

20. When you completed rehabilitation, were you given the same job assignment, or not? (Check one) _____ (44)

1. Yes 2. No

21. Did you want the same job back again? (Check one) _____ (45)

1. Yes 2. No

Form K-1 (continued)

22. When you entered rehabilitation, did your pay grade increase, decrease, or stay the same? (Check one)
1. Increased 2. Decreased 3. Stayed the same (46)
23. When you completed rehabilitation, did your pay grade increase, decrease, or stay the same? (Check one)
1. Increased 2. Decreased 3. Stayed the same (47)
24. How about now, is your pay grade higher, lower, or the same as when you completed rehabilitation? (Check one)
1. Higher 2. Lower 3. Same (48)
25. In your opinion, what percent of people in rehabilitation here on this post really need such services? (Check one)
1. 5% or less 4. 26-50%
 2. 6-10% 5. 51-75% (49)
 3. 11-25% 6. 76-100%
 7. Don't know
26. In your opinion, what percentage of people on this post who are not in rehabilitation should be? (Check one)
1. 5% or less 4. 26-50% (50)
 2. 6-10% 5. 51%+
 3. 11-25% 6. Don't know

Form K-1 (continued)

27. In your opinion, does rehabilitation help people stop using drugs or drinking too much, or not? (Check one) (51)
- 1. Yes -- helps all people stop
 - 2. Yes -- helps some people stop
 - 3. No
 - 4. Don't know
28. In your opinion does rehabilitation help people cut down on drugs or excessive drinking, or not? (Check one) (52)
- 1. Yes -- helps all
 - 2. Yes -- helps some
 - 3. No
 - 4. Don't know
29. In your opinion, does rehabilitation help drug users to switch to less harmful drugs, or not? (Check one) (53)
- 1. Yes -- helps all
 - 2. Yes -- helps some
 - 3. No
 - 4. Don't know
30. Do you have any other comments you'd like to make about rehabilitation? (Record verbatim)

Time Completed

Thank respondent and terminate.

FORM K-2

SAMPLE INTERVIEW FOR SUPERVISORS OF REHABILITATION "GRADUATES": KEYPUNCH
VERSION

SUPERVISOR INTERVIEW

Interviewer _____ Interview No. _____

Day/Date _____ (1) (2) (3) (4)

Time Begun

I. INTRODUCTION

(Introduce yourself) We are conducting a study of programs on this post dealing with problems of drugs and alcohol.

Your answers to this questionnaire will be held in the strictest confidence. Your answers to this survey will help the Army to develop better drug/alcohol programs.

You were chosen for this interview because you are the immediate supervisor of (*give soldiers' name*) who has recently completed a drug/alcohol treatment or rehabilitation program on this post, which I'm going to refer to as "rehabilitation."

II. PRE-REHABILITATION BEHAVIOR

First, I'd like to ask you some questions about his/her behavior just prior to entering rehabilitation.

1. Were you his/her supervisor just prior to his/her entering rehabilitation? (Check one)

 1. Yes 2. No (Skip to Section III) (5)

FORM K-2 (Continued)

2. In the 6 months before rehabilitation, was he/she involved in any disciplinary actions or not? (Check one)

1. Yes

2. No

3. Don't know

(6)



Go to Q. 3

About how many, would you say in that time? (Check one)

1. 1

4. 7 or more

(7)

2. 2-3

5. Don't know

3. 4-6

3. In the 6 months before rehabilitation, was he/she involved in any fights, or not? (Check one)

(8)

1. Yes

2. No

3. Don't know



Go to Q. 4

About how many, would you say, in that time? (Check one)

(9)

1. 1

4. 7 or more

2. 2-3

5. Don't know

3. 4-6

4. How would you characterize his/her relations with others in the unit in the 6 months before rehabilitation: excellent, good, fair, or poor? (Check one)

1. Excellent

4. Poor

(10)

2. Good

5. Don't know

3. Fair

5. How would you characterize his/her discipline during that time: excellent, good, fair, or poor? (Check one)

1. Excellent

4. Poor

(11)

2. Good

5. Don't know

3. Fair

FORM K-2 (Continued)

6. How satisfied would you say you were with his/her job performance during that time: would you say very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied? (Check one)

1. Very satisfied 4. Very dissatisfied (12)
 2. Somewhat satisfied 5. Don't know
 3. Somewhat dissatisfied

7. Had he/she had any pay grade changes in the 6 months before entering rehabilitation? (Check one)

1. Yes 2. No 3. Don't know (13)
↓ Go to Section III

Did the paygrade increase or decrease? (Check one)

1. Increase 2. Decrease (14)

III. BEHAVIOR SINCE REHABILITATION

I'd like to talk now about things since rehabilitation.

1. Since rehabilitation has he/she been involved in any disciplinary actions, or not? (Check one)

1. Yes 2. No 3. Don't know (15)
↓ Go to Q. 2

About how many, would you say? (Check one)

1. 1 4. 7 or more (16)
 2. 2-3 5. Don't know
 3. 4-6

FORM K-2 (Continued)

2. Since rehabilitation has he/she been involved in any fights,
or not? (Check one)

1. Yes 2. No 3. Don't know (17)
↓
Go to Q. 3

About how many, would you say? (Check one)

1. 1 4. 7 or more (18)
 2. 2-3 5. Don't know
 3. 4-6

3. How would you characterize his/her relations with others
in the unit since rehabilitation: excellent, good, fair, or
poor? (Check one)

1. Excellent 4. Poor (19)
 2. Good 5. Don't know
 3. Fair

4. How would you characterize his/her discipline since rehabilitation?
(Check one)

1. Excellent 4. Poor (20)
 2. Good 5. Don't know
 3. Fair

5. How satisfied would you say you are with his/her job
performances since rehabilitation -- very satisfied, somewhat
satisfied, somewhat dissatisfied, or very dissatisfied?
(Check one)

1. Very satisfied 4. Very dissatisfied (21)
 2. Somewhat satisfied 5. Don't know
 3. Somewhat dissatisfied

FORM K-2 (Continued)

6. Has he/she had any paygrade changes since rehabilitation?

(Check one)

<input type="checkbox"/> 1. Yes	<input type="checkbox"/> 2. No	<input type="checkbox"/> 3. Don't know	(22)
---------------------------------	--------------------------------	--	------

↓
Go to Section IV

Did the paygrade increase or decrease? (Check one)

<input type="checkbox"/> 1. Increased	<input type="checkbox"/> 2. Decreased	(23)
---------------------------------------	---------------------------------------	------

IV. RESULTS

I'd like you to consider now what effects, if any, rehabilitation has on the use of drugs and alcohol.

1. Do you think this individual should have been in rehabilitation or not? (Check one)

<input type="checkbox"/> 1. Yes	<input type="checkbox"/> 2. No	<input type="checkbox"/> 3. Don't know/no opinion	(24)
---------------------------------	--------------------------------	---	------

2. Do you think rehabilitation was excellent, good, poor, or very poor at helping him/her stop drug use/problem drinking? (Check one)

<input type="checkbox"/> 1. Excellent	<input type="checkbox"/> 4. Very poor	(25)
---------------------------------------	---------------------------------------	------

<input type="checkbox"/> 2. Good	<input type="checkbox"/> 5. Don't know/no opinion
----------------------------------	---

<input type="checkbox"/> 3. Poor

3. Do you think it was excellent, good, poor, or very poor in helping him/her get himself/herself together? (Check one)

<input type="checkbox"/> 1. Excellent	<input type="checkbox"/> 4. Very poor	(26)
---------------------------------------	---------------------------------------	------

<input type="checkbox"/> 2. Good	<input type="checkbox"/> 5. Don't know/no opinion
----------------------------------	---

<input type="checkbox"/> 3. Poor

FORM K-2 (Continued)

4. To your knowledge, did rehabilitation help him/her stop drug use/
problem drinking, or not? (Check one)

1. Yes (Skip to Q. 7) 2. No 3. Don't know | (27)
Go to Q. 5

5. In your opinion, did rehabilitation help him/her cut down on drug use/
problem drinking, or not? (Check one)

1. Yes 2. No 3. Don't know (28)

6. Do you have any other comments you'd like to make about rehabilitation?
(Record verbatim)

 Time Completed

End of Card 1 1
(80)

Thank respondent and terminate

FORM K-3

SAMPLE FORM FOR OBJECTIVE DATA ON
EACH REHABILITATION ENTRANT IN SAMPLE

	<u>Identification No.</u>	(1)	(2)	(3)	(4)
1. Date entered rehabilitation:	<u> / / </u>	month	day	year	(5-10)
2. Date left rehabilitation:	<u> / / </u>	month	day	year	(11-16)
3. Was rehabilitation completed?	<u> </u> 1. Yes <u> </u> 2. No	(17)			
4. Has soldier been discharged?	<u> </u> 1. Yes <u> </u> 2. No	(18)			
a. Was soldier discharged early?	<u> </u> 1. Yes <u> </u> 2. No	(19)			
b. What discharge was given?	<u> </u> 1. Honorable <u> </u> 2. Medical <u> </u> 3. Other	(20)			
c. Was discharge given immediately after rehabilitation?	<u> </u> 1. Yes <u> </u> 2. No	(21)			
5. Was soldier returned to same unit?	<u> </u> 1. Yes <u> </u> 2. No	(22)			
6. Was soldier given same job?	<u> </u> 1. Yes <u> </u> 2. No	(23)			
7. Was soldier kept at same paygrade?	<u> </u> 1. Yes (Go to Q. 8) <u> </u> 2. No	(24)			
↓					
Was paygrade:	<u> </u> 1. Increased <u> </u> 2. Decreased	(25)			
8. Has soldier received any subsequent disciplinary actions?	<u> </u> 1. Yes <u> </u> 2. No	(26)			
9. Has soldier subsequently been confirmed again as a drug user/ problem drinker?	<u> </u> 1. Yes <u> </u> 2. No	(27)			
10. Has soldier reentered rehabilitation?	<u> </u> 1. Yes <u> </u> 2. No	(28)			

FORM K-4

SUMMARY DATA: 100% SAMPLE OF REHABILITATION ENTRANTS
OVER A SIX-MONTH PERIOD*

(To Be Gathered A Year After that Period)

I. Satisfactory completion of rehabilitation

1. Total entrants _____
2. Completed rehabilitation satisfactorily _____
3. Did not complete rehabilitation satisfactorily _____
(1 - 2 = 3)

II. Remained in Army immediately after rehabilitation

4. Yes _____
5. No _____
(4 + 5 = 1)

III. Returned to same unit after rehabilitation

6. Yes _____
7. No _____
(6 + 7 = 4)

IV. Returned to same job after rehabilitation

8. Yes _____
9. No _____
(8 + 9 = 4)

V. Pay grade change since end of rehabilitation

10. Higher _____
11. Same _____
12. Lower _____
(10 + 11 + 12 = 4)

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*See Figure K-1

FORM K-4 (Continued)

VI. Disciplinary action received after rehabilitation

13. Yes _____

14. No _____

(13 + 14 = 4)

VII. Number of disciplinary actions received after rehabilitation

15. One _____

16. Two _____

17. Three _____

18. Four or more _____

(15 + 16 + 17 + 18 = 13)

VIII. Confirmed again as problem drinker/drug user

19. Yes _____

20. No _____

(19 + 20 = 4)

IX. Reentered rehabilitation after second confirmation

21. Yes _____

22. No _____

(21 + 22 = 19)

X. Remained in Army immediately after second confirmation

23. Yes _____

24. No _____

(23 + 24 = 19)

FORM K-4 (Continued)

XI. Type of discharge

From 5, Did not remain in Army immediately after (first) rehabilitation

25. _____ Honorable

26. _____ Medical

27. _____ Other than Honorable

(25 + 27 = 5)

From 24, Did not remain in Army immediately after second confirmation

28. _____

29. _____

30. _____

(28 + 30 = 24)

XII. Reached date of programmed expiration of term of service

From 4, Remained in Army immediately after (first) rehabilitation

31. _____ Yes

32. _____ No

(31 + 32 = 4)

From 23, Remained in Army immediately after second confirmation

33. _____

34. _____

(33 + 34 = 23)

XIII. Reenlisted

35. _____ Yes

36. _____ No

(35 + 36 = 31)

37. _____

38. _____

(37 + 38 = 33)

XIV. Type of discharge

39. _____ Honorable

40. _____ Medical

41. _____ Other than Honorable

(39 + 41 = 32)

42. _____

43. _____

44. _____

(42 + 44 = 34)